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PRESIDENT'S ADDRESS

It is indeed a pleasure for the Officers and the Board of Directors of the National League of Nursing Education to meet again with the membership, and a privilege for your president to have an opportunity to report directly to you. It is now over three years since this organization assembled in convention, and over two years since the Board, the Advisory Council, the Committees, and a limited number of members met in Buffalo. Meanwhile, far reaching events in nursing and nursing education have moved along in significant succession: the war, the splendid response of nurses to both military and civilian needs, the nation-wide organization of nursing for coordinated planning, the rapid and effective response of schools of nursing to radical changes in curriculums, the continued shortage of nurses for all types of work, the disturbing realization that "the good old days" of the pre-war era would not return and that progress, like it or not, does not turn backward.

How the League met the problems of the final year of the war was reported to you in the Annual Report for 1945. How the League has met the problems of the first year of peace, and how we plan to meet the year to come is to be reported to you today.

With the end of the war, came the dissolution of the special Committee on Educational Problems in War Time. This Committee carried a major portion of the responsibility for studying school problems during the war years. The outstanding contributions of this Committee included the publication of Bulletins which were sent to every state accredited school in the Country, and a series of institutes conducted with the Association of Collegiate Schools of Nursing on problems of the collegiate school. The assistance given by both of these programs will continue far beyond the war years. Both programs reflect the high standards and the educational leadership of the Committee and its

Chairman, Miss Nellie X. Hawkinson. The Bulletins, now sold in one volume, and the manual on collegiate school organization will furnish sound guidance during this post-war period of deceleration and reconstruction of school programs.

It may well be said that the dissolution of the Committee on Educational Problems in War Time represents our only loss this past year. Certainly in terms of numbers this is true. Three newly organized State Leagues have joined the National, Montana, Mississippi, and Vermont. Individual membership which stood at in 1944 is now at , an increase of members. This growth is a tribute to the Committee on Membership Campaign and especially also to the State and Local Leagues which have conducted active programs so pertinent to the local need.

As the membership of an organization grows, so must the staff which serves this membership be increased. This year provision has been made for 4 more full time and 2 more part time professional members of the staff. Four of these have been secured and are already at work. All four come to the League as specialists with outstanding preparation for the positions they fill. Miss Ida McDonald joined the staff of the Committee on the Administration of the Accrediting Program as a field visitor in the fall of 1945, and has already been active in the field. Through the increased grant from the Infantile Paralysis Foundation, the League now has funds to employ a second nurse consultant in orthopedic nursing. To this position Miss Kathleen Newton, a former orthopedic scholarship student, was appointed. For some time the National Organization for Public Health Nursing has had the services of a nurse consultant in tuberculosis nursing provided by the National Tuberculosis Association. Through the encouragement and the help of the National Organization for Public Health Nursing this year, the League has also secured aid from the Tuberculosis Association. On September first, Miss Katherine Amberson assumed her duties as consultant in tuberculosis nursing for the League. Since its inception, the Chairman with

her Committee on Measurement and Educational Guidance has carried an increasingly heavier administrative load, heavier by far than volunteer committee workers commonly assume over long periods of time. The work has been well done, but the Committee and Chairman should no longer be rightfully expected to carry it. As director for this highly specialized work, the Committee has secured the services of Miss Elizabeth Kemble. For the present, Miss Kemble, who is working for the doctorate in this field, will give only part time to the League. In the 1946 budget, funds were provided for two other staff members, one the Assistant Executive Secretary for Field Service, the other a part time Assistant to the Committee on Public Relations. Both are important positions and should be filled without fail before the end of the year. All six of these new staff members have been sought that the services of the League may be more readily available to the membership, and that the State, Local, and National programs may be more closely integrated.

Because of the far reaching import of the programs under consideration this year, the Board of Directors has met three times, the Committee Chairmen were called together in October and the Advisory Council was asked to assemble in January with the Board of Directors. The program of the organization in general has been carried on as usual in five major areas: programs related to undergraduate nursing education, programs concerned with education for the graduate nurse, in part especially for the veteran nurse; programs concerned with post-war planning, with legislation and with the study of organization structure and functions, both of our own organization and of all the national professional nursing organizations.

We have been fortunate in securing grants to support the work of some committees. These have been given by the American Journal of Nursing, the Infantile Paralysis Foundation, and the National Tuberculosis Association.

Through this assistance the Committee on Post-Graduate Clinical Courses has been able to bring together the necessary committees to work on advanced courses in obstetrical and surgical nursing, orthopedic nursing, and tuberculosis nursing.

Two outstanding manuals are to be added to the list of League publications this fall. The "Faculty Pamphlet", a completely revised manual, was prepared by a special committee under the chairmanship of Miss Isabel M. Stewart. This manual adds one more to the already important group of League publications in which Miss Stewart's personal and educational leadership is evident. We are fortunate that she could give the time to complete the "Faculty Pamphlet" in spite of the pressure of work in the International Council of Nurses. Although the League received no funds for it, the second publication, a pamphlet on "Guidance Programs for Schools of Nursing" is in a sense the result of a grant. We are indebted to the U. S. Office of Education, for the time given by Mr. Fred Fowler of that Office to write the pamphlet. We are indebted to the U. S. Public Health Service for the provisions for Mr. Fowler to visit schools of nursing in preparation for writing the pamphlet. A third publication prepared by the Committee on Psychiatric Nursing will furnish schools an enlarged, comprehensive, and helpful bibliography in that field.

It is not within the scope of all committees to prepare publications; all cannot have extra funds to employ full time workers, all cannot have special grants to make possible frequent meetings of working groups whose accomplishments stand out in somewhat more spectacular manner. But that every committee has been active and has achieved noteworthy success within the scope of its own objectives is of itself important. It is through the work of such volunteer committees that the League has grown quietly, steadily, and surely.

Post-war planning which began in Buffalo in 1944 culminated in the "Comprehensive Program for Nation-Wide Action in the Field of Nursing" published

in 1945. In this plan were embodied our post-war plans and our highest hopes for opportunities which would lead toward a system of nursing education adapted to the post-war era. This fall, 1946, the National Nursing Planning Committee ends its large and active program. Many of the League plans included in the "Comprehensive Plan" have not yet gone beyond the stage of planning because of inability to secure funds. The "school study" has not developed as planned, the recruitment program is not assured, the curriculum study, the joint plans for accrediting, the joint plans for counseling to schools, the special plans for research in educational measurement, all these are either still in blue print or in the stage of exploratory planning. We believed these plans to be vital to nursing education and to nursing. If we still believe this to be a fact, we must be ready to answer how are we to push them beyond the blue print stage, how are we to put the plans into effect, how are we to support them in the future. These are after all no greater than the questions answered by nursing during the war. Surely they deserve the same effort, the same support as the questions put by the war emergency. Surely nursing today is facing an equal emergency.

In Buffalo in 1944 it was also voted that the three larger national professional nursing organizations should study their structural plans to see wherein a more effective structure might be devised. The three other national professional organizations were invited to participate, making the study a very comprehensive one. This study has now been completed and the results are ready for your consideration. Nursing united is truly far greater than the sum of the six individual organizations, far greater perhaps than those who planned the study could anticipate. Actually the plan is too large, too comprehensive for the considered judgment that it needs during these meetings. It must be analyzed by your appointed representatives in terms of philosophy,

structure, function, and probable productivity. It must be studied in terms of what nursing should be, not what it now is, in terms of our reach and not our grasp.

In the meantime while our representatives are studying the new plan, the League program must go on. With the idea that the better our organization, the better it would fit into any possible new plan, the League undertook in committee this year a study of Headquarters' organization and a study of personnel policies for the staff. The former study continues, the latter is completed for the present. The League has also continued its plans for revision of the by-laws with respect to broadening the basis of membership and to advancing the dues. The League which represents nursing education needs and warrants the support of a large and active membership. It warrants also the financial support which will make possible continuance of existing programs and the initiation of new programs to meet emerging needs. The increased membership, the sale of publications and records, the grants for special studies have been sufficient this year to carry on the program planned. We have expanded some activities and we have met our obligations as a participant in joint professional projects. In addition Miss Mayo as secretary, and Miss Pfeifferkorn as treasurer of the Promoting Committee for the Structure Study have given many extra hours of work. But all this is not enough. The influences of the war have continued this year to curtail many of our activities, committee travel has been nearly minimum. A field secretary must have office space and secretarial service. The studies needed to prevent a lag between service needs and educational planning may well require more workers in our Department of Studies. Leadership requires knowledge; the source of such knowledge is research.

It is not the function of the League to attempt to participate in legislation either on the State or National level. The American Nurses'

Association rightly represents all nursing in this respect. But it is the function of local, State, and National Leagues to be informed of pending legislation with implications for health and education. It is also our function to respond if invited to speak. This spring a special Committee on Legislation was appointed to study pending bills and to prepare a statement for the League. This statement was presented by the President at the hearing on the "Maternal and Child Health Bill" and later filed at the hearing of the Wagner-Murray-Dingell Bill.

Each year as the ballot is prepared, we cannot but be aware of the pending changes in Officers and Board members. I do not wish to close this report without a word of two members who were nominated by the States but requested that their names not be placed again on the ballot this year. One is Miss Nellie X Hawkinson, a member of the Board since . The second, Mrs. Thomas R. White, a member of the Board for one term and the first lay member to be elected to that office. Both will be greatly missed, Miss Hawkinson for her thorough knowledge, her wise judgment, and her sincere interest in the League, Mrs. White for her understanding, her interest, and her efforts to introduce a public relations program which would show to others the values she herself found in the League's program.

In concluding, I wish to express my appreciation to the members of the Headquarters Staff who have assumed so willingly and effectively the added responsibilities of the growing program. I wish also to express my regret for the inability to accept more invitations to attend state meetings. I have chosen these past two years, in lieu of state meetings, to attend those of the National Nursing Council, the National Planning Committee, the Promoting Committee for the Structure Study, the Advisory Committees of the American Red Cross, the Children's Bureau, and the Veteran's Administration.

"We have harder things to do than were done in the heroic days of the war, because it is harder to see clearly, it requires more vision, more calm balance of judgment, a more candid searching of the very springs of right." Surely furnishing the nursing to make and keep a great nation healthy is an even greater challenge than furnishing the nursing for that nation's military forces!

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At last the time has come for the class of 1947 to join the profession of nursing, a profession which holds opportunities unequalled in most fields of public service open to women. For you, the members of the class, this year is an ending and a commencement. It is the end to three years of preparation and the beginning of a new and satisfying life.

Entrance into professional life, like entrance into a new country, requires both passport and visa. The passport is required to secure formal admission into the profession; the visa is an additional endorsement of acceptability as a broadly trained, and capable practitioner. The diploma will be your passport. It will be yours because you have studied and worked to achieve it. The visa will be yours, a precious heritage, because you chose to enter a school whose parent hospital is known and respected throughout this country and in many countries throughout the world. Over the years, the reputation of "M.G.H." has been built by the high standards and outstanding achievements of men and women from all Hospital Services. Now, you, who have studied and worked in the same wards where these great men and women worked, have inherited the benefits of the reputation they have built. This reputation is the endorsement, a visa on your diploma. It verifies your clinical preparation as sound and broad, it recommends you as one ready to give the newest and best in nursing care, it bespeaks for you opportunities for service and study, it paves the way for a satisfying personal life. It may, by its inherent values, also challenge you in return to contribute your measure to the greatness of the Hospital and School of Nursing. As this contribution may be the result of unusual ability in research or eminence in education, or the result of every day conscientious effort to do well that work which needs to be done, every graduate is privileged to do her share.

Preparation and recommendation you now possess! Opportunities of all kinds lie before you; nursing at home and abroad, institutional and public health positions, the chance to earn, and the chance to learn. All these are yours, and more. For there is too the opportunity of citizenship in a world which needs the understanding of women, the knowledge of the health worker, the strength of youth. Your School stands behind you, your career lies before you. What you make of it depends now upon you.

PAST, PRESENT AND FUTURE IN NURSING AT M. G. H.

Near the entrance to the Supreme Court Building in the City of Washington there is written a simple phrase which seems to speak most aptly for the past, present, and future of nursing at M.G.H. The phrase reads simply - "Past is prologue." The past, a preface, an explanation for the present, and an introduction to the future. We, here tonight, represent the past of nursing at M.G.H., we are the present, and we shall in some small way, alone, and with great strength together, wield an inestimable influence upon the future. This brief discussion is really about us, about our forbears at M.G.H., and about the future which we purposefully or unwittingly help to build.

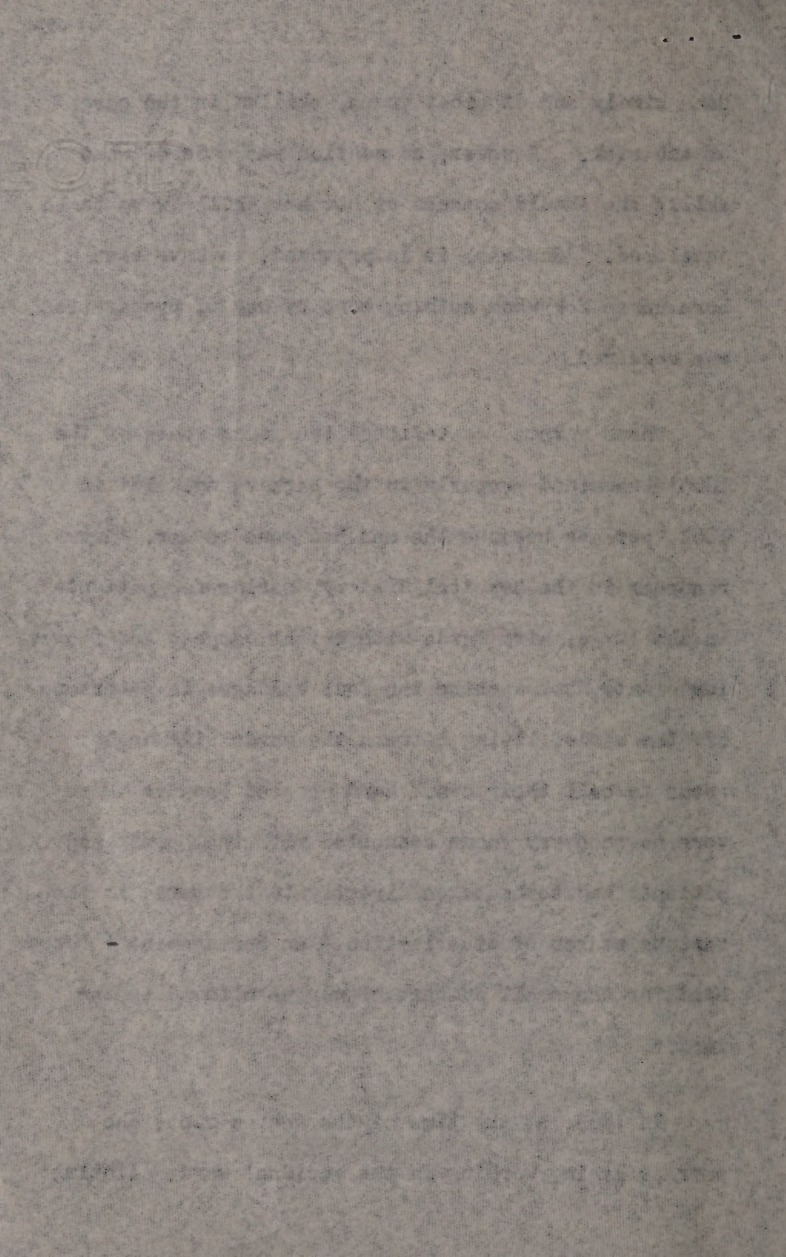
Our ancestors in M.G.H. nursing first appear in print in 1810 when letters were sent out requesting financial aid to build the hospital. The concept seems to have been that the nurse was a necessary adjunct to the hospital staff, that her duties were laborious and painful, that she should

SYNCHRONIZED

be a kindly and discreet woman, skilled in the care of the sick. However, no mention was made of what skills she should possess or how her skills were to be developed. She was, it is presumed, to have been a born nurse for whom nothing more by way of preparation was required.

These nurses, as befitted the young women of the 1860's remained properly in the background. But in 1862, perhaps because the men had gone to war, they reappear in the hospital History, caring for patients in the large, airy wards with bright carpets and flowering plants, but washing the foul bandages in bathrooms off the wards, living between the wards with no bed rooms to call their own, "hard pressed because there were no recovery rooms connected with the Dome", and patients had to be taken directly to the wards in the various stages of etherization - an arrangement - "very hard for the small numbers of nurses allowed to the ward."

In 1863, at the time of the Boston riot, she emerges again, working in the accident ward, pointing



out as a result of those experiences "the need for educating women in the art of nursing the sick - an art which up to that time they had apparently been supposed to know by intuition, - blamed for their ignorance if they failed in some point", and -- "reprimanded rather unpleasantly if they knew too much."

So our ancestors paved the way for the School which was "to open a new career for women" in 1873. The Trustees proposed at that time to assign two wards in "The Brick" to the ministrations of the School. "The Brick" was chosen for this trial because of its peculiar appropriateness. It stood by itself; it represented both medical and surgical departments; and it offered the hard labor desirable for the training of nurses. In spite of this reluctant assignment, the Trustees specified that training essential to good nursing should be given, and by 1875 the value of the School was demonstrated to the extent that all wards were placed in charge of the Training School for nurses. In fact, in

RECORD

1876 the annual report states that "these women with right notions of their duties will eventually prove a blessing to the sick of all classes in the Community." The notions apparently were right for each succeeding annual report records the progress of the school.

To separate the past, the present and the future even for purposes of discussion seems almost impossible. In a sense, I have summarized a bit of our past. Shall the present begin with the years we here tonight have known? If so, the present for some is this twentieth century; for others it is only the years of rapid change since World War I. Or, shall the present begin when the philosophies of education and principles of nursing simulate our own today? If so, the present is in truth ageless. To sense this fact I would refer you to a small volume in our nursing literature. If you are in active practice, you will find consolation, encouragement and relaxation. If you are no longer active in nursing, you will find sheer joy in reading

its pages again. I refer to our own Miss Parsons' History of the Massachusetts General Hospital Training School for Nurses. There you will find recorded that in 1879 Mrs. Parkman requested an endowment for the School; that in 1881 Miss Maxwell "found insufficient and unsuitable accommodations for the nurses, and the scarcity of applicants a problem." It is added further that "the excessively hard work in the School was evidently becoming a detriment to its popularity."

And for the years through the 90's Miss Parsons writes - "it always seemed as if more was required from the pupils than it was humanly possible to accomplish but pupils learned under that system that their capacities exceeded their expectations."

But there were tragic and amusing occurrences in those busy days as there are today. It was doubtless no error that heat was not piped into the rooms in Thayer for bedrooms were not commonly heated in the 80's. But it must surely have been a surprise to all concerned that the beds furnished for the new residence were without springs.

BEES INC

How the nursing care of patients changed over the years can best be traced through the records of medical science here and in other institutions. The post-operative patients to special from this new "etherization"; the first T.P.Rs taken by the nurses when Linda Richards ordered a thermometer for the School in 1874; the gradual changes in nursing routines when Dr. Homans first operated with the new antiseptic techniques, when Dr. Wright's pathology laboratory was opened in 1896 and when the X-Ray was established in that same year by Dr. Todd. It is hard to imagine how the new developments changed those quiet, airy wards into busy human but equally humane laboratories. The time absorbing typhoid baths of the early 1900's, the dakins dressings for the many empyema patients of the postwar years of World War I. The inevitable transfers from upper wards to C and D and back again. The addition of 300 semi-private beds on the opening of the Baker Memorial in 1930.

The new intravenous procedure, the morphine by the clock. In 1935 we counted the ^{number of} hypodermics ^{given daily} concerned because such large amounts of time were being

absorbed by this procedure. 165 hypodermic injections in the General Hospital in one day. Imagine, Ward C-D had 42 in one day. Today we seek the deeper tissues. No more do we count in such small figures the hypodermic injections. Now, the intramuscular penicillin injections number 650 - 700 daily. But gone are many of the septic dressings, gone are the long periods of hospitalization, come is the miracle of the new medicine and surgery and the modern nursing.

Through all the changes the kind and skillful nurse has been needed to complete the medical science team. She has twice gone to military service beside the doctors of M.C.H. Because her number on M.C.H. wards was too few, new workers have been added to the ward staff: the licensed attendant, and the hospital aides trained on the job.

Because it was necessary that her skill keep pace with medical needs, her instruction has been increased and reorganized periodically over the years. That those who wished to bring the broader education *under Miss Johnson's able direction* to nursing might be included, a coordinated program

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was established with Radcliffe College. To this program next year will be admitted two daughters of M. O. H. Alumnae.

Such is the present, the prologue of the future. Certain omens there are for nursing in the years ahead. The new children's building with 70 beds, which will provide better care for children, broader pediatric experience for the school, and a new field of work for graduates; the planning for a new nurses' residence already underway to provide better living facilities for the School; continuing curriculum study to maintain the advancement necessary to meet the new developments in medicine and surgery, and to maintain a school which will prepare nurses not alone for the care of the sick, but for the maintenance of health as well; continuing analyses of nursing service needs to develop new techniques, and to furnish better care of patients; understanding and cooperation from Trustees and Administration which includes time to study our problems.

Where shall we go in the future? Only a sibyl,

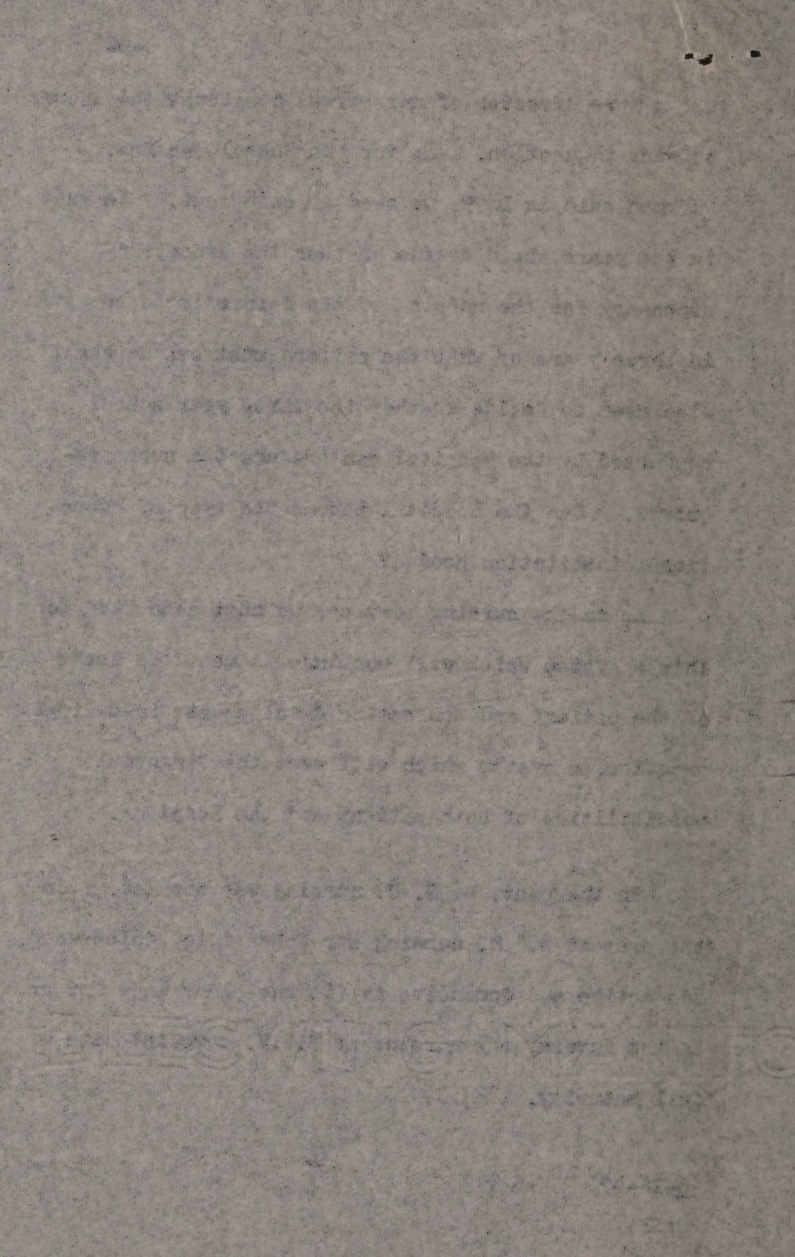
not a mere director of nurses would attempt the answer to such a question. As for the School, as Mrs. Parkman said in 1879, we need an endowment. We must in the years ahead decide whether the education necessary for the nursing of the future is to be given in three years or what the pattern must be; we shall also need to decide whether the three year school conducted by the Hospital can produce the nurse required. Can the Hospital become the type of educational institution needed?

As to the nursing service, we must also find for this a system which will continue to meet the needs of the patient and the coming developments in medical practice, a system which will meet the financial possibilities of both patient and the Hospital.

In the past, M. G. H. nursing was created. In the present M.G.H. nursing stretches into adolescence, too active and demanding to fit the plans made for us. In the future, may nursing at M.G.H. come into its full maturity.

6-14-47

RS:EP



ISSUES RELATING TO THE CONTENT AND LENGTH OF THE BASIC CURRICULUM IN NURSING

The issues connected with the length and content of the basic curriculum in nursing are the fundamental issues of the process of curriculum construction itself. Content selection is primarily dependent upon the aim of the school and the aim of the school follows naturally the philosophy adopted by those who conduct it. A discussion of the issues relating to content would seem therefore to begin most logically with a discussion of the issues concerned with the philosophy of the controlling institution and the school of nursing.

If schools of nursing were commonly independent educational institutions, or were always conducted by institutions concerned only with education, we should turn at once to philosophies of education to make our selection. If we are practical in our approach to the subject we will begin with the general principles which guide the program of the hospital as a whole. Then we will turn in particular to the principles which guide the hospital's activities related to education of nurses.

The first issue to be considered might pertain to the size of the hospital which conducts the school. I would not measure this size by bed capacity, or numbers of personnel employed, or size of the nursing staff, or the amount of the annual budget. All of these have importance, and we shall doubtless refer to them again and again this week, but I would not choose them as my yardstick. Instead, I would measure the hospital by the philosophy or principles which guide its operation. Does the hospital consider its responsibility to be only the care of the patient from the day of entrance to the day of discharge, does the hospital consider its responsibility to the patient only in terms of the care to be given within the four walls of the institution, good care to be sure but care narrowly envisioned? The institution which meets such a standard according to one yardstick is a small hospital. Or does the hospital consider its function to be a large community responsibility with an

obligation for the health and welfare of the community including considerations for patients before and after admission, or even those individuals who will never need the hospital's services per se? The institution which can stretch to meet this standard according to one yardstick will be a large hospital.

The second issue might pertain to the relationship of the nursing service and school to the other services offered by the hospital, medical and surgical only, or to these plus other special services such as special clinical services or such as dietary, social service, and the like. What is expected of the nurse in the hospital? Is she to be the handmaiden of the past, for she could so continue even in a hospital where other professional groups were marching ahead? Or is the nurse expected to keep pace with other groups, to take her place on the administrative team for general planning within the hospital, the medical team for planning over all patient care in the hospital, the community team which integrates the hospital with other services into an effective community health program?

The decision on these first two issues may determine for you the philosophy and aim of your school. Is it to prepare a worker to give narrow, routine care to the sick within the institution only, or is the school of nursing to prepare workers to share in "health conservation in its widest sense, including the care of normal children and adults; the nursing or nurture of the mind and spirit as well as the body; health education as well as ministration to the sick; the care of the patient's environment, social as well as physical; and health to families and communities as well as to individuals."¹

Obviously, the latter aim will lead to a more costly curriculum for it will require facilities not now possessed by most institutions; it will require more adequate faculties, both in numbers and in preparation than most schools of nursing

now employ. A fourth issue might then be related to costs - can the controlling institution afford to give the school of nursing such curriculum content, or can the hospital afford not to find a way to fulfill its obligation to the patient, the community, to medical practice, and to the young woman admitted to its school of nursing.

Thus far I have not mentioned that the product of this educational program the student nurse - might have some influence on the content chosen. If our philosophy is to consider issues including the democratic principle, we must decide whether students' interests and welfare are adequately considered in the selection of the content she is to learn. Much has been written and said about recruitment over the past seven years. This is not the place to discuss that topic, but as every area in the school program affects all other areas, it should not be forgotten that a school's curriculum is one of the most attractive recruiting devices. And this attraction is greatest when individual differences and needs of the students are considered in selecting the courses and their content. What will give content a student appeal? What does the high school or college student want when she enters nursing? Obviously, she does not go into nursing school because she wants to spend three years taking care of the hospital's patients. She will like to take care of these patients at the proper time, but she goes to the school because she wants an education in nursing, and she wants some of the concomitants which go with educational programs for adolescent girls. In this fact might lie another significant issue. What is considered educational by the 18 or 20 year old girl? How does she measure the educative ability of a curriculum? By her high school program, by her college experiences, by her brothers' and sisters' reports of college life and learnings, by the achievements of graduates of the school, by her own needs, by her dreams? Will she find satisfactions just in learning how to take care of the sick or will she seek, too, to gain a broader vision of life and to develop her

individual capacities as a young woman? Will she be a better nurse if these capacities are developed? Will she be content with knowing the how's of doing, or will she need the satisfactions in knowing the why's of what she does? Will she look for those elements which will give her security in her student practice? Will she expect to be taught subjects which will give her satisfactions in her graduate years? Will she want to know what is going on in this exciting search for health inside and outside the institution which will enable her to participate in the search too?

Should she be prepared to start in her career as a general type of practitioner, able to care for patients, men, women, and children, with a wide variety of conditions, medical, surgical, obstetric, pediatric, psychiatric, or should she be able to care only for general medical, surgical, obstetrical, pediatric? Should she know how to care for some of the chronic diseases so prevalent in the community, i.e. tuberculosis? Is it sound to consider the preparation of nurses in one or two fields only, that is, to work only in medical and surgical units? Is such a thing possible as specialization before generalization? The specialist is usually considered to be a person who learns "more and more about less and less until he knows everything about nothing". But he has begun with a broad knowledge, and narrowed as he specialized. To begin with a specialty, without a solid foundation of knowledge, would almost be a matter of learning less and less all the time about nothing.

Thus far the issues listed have pertained (1) to the philosophy and aims of the hospital and the school, are they to be broad, in keeping with present best trends and forward looking, (2) to the principles which determine the relationships of the school, (3) its standing in the institution, (4) to the needs of the student as an individual, (5) to the needs of the graduate as a woman and a practicing nurse.

Such issues as I have discussed, others which you will wish to add, cannot be taken customized tailored for application in every school. They may be in general fitted to every school for there are common factors in every educational institutions. But every institution will need a body of persons whose functions it will be to study the ready made issues, apply them to their own situation, and also ferret out specific issues which pertain only to that particular institution.

Who is to constitute this body? Shall it be the faculty of the school, the administration of the hospital, the medical staff or other groups closely related to nursing service or sharing in the instruction of the students? If the school of nursing is in truth a school, should this function not be the responsibility of the school faculty as in other types of educational institutions? If the philosophy of the institution is a democratic one, the committees might rightly include members of the hospital administration, the members of the medical staff and other staffs who share in the teaching of the students, or who can best interpret medical, social and health needs of the hospital and the world outside the hospital. In terms of an educational institution, the major responsibility should lie in the hands of the faculty entrusted with the conduct of the school. For the same reason, the school faculty should also seek the advice of capable persons from general education.

All this time I have used the word content, but I have not defined it. What is this so-called "content" of the curriculum which we are considering. In general education, the curriculum content for a school indicates the individual courses and their aims and subject matter. It may give the methods by which the subject matter is to be taught and sometimes indicates the facilities necessary for the instruction. The curriculum for nursing would be comparable except for one major difference - that is the ward practice or the experience which the student nurse is privileged to have in a great human laboratory. In this respect the

student nurse is different from other students in similar stages of preparation. She begins almost immediately to assume responsibility for the patients' welfare. Because of this fact we who plan the content of courses in nursing face several issues not found in other fields of education. How much instruction must the student have before she begins to go to the ward for experience? How much instruction in the physical and biological sciences is necessary to understand the principles she is to apply on the wards? How much social science is necessary to meet the demands of the broad health and social program? What instruction is necessary to convert an 18 or a 17 year old adolescent girl into a stable, professional student with the judgment demanded during patient care? What type of instruction in the classroom and guidance on the ward assignment is necessary to develop students who can think for themselves? Do we want content which will make students think for themselves? Must students have clinical assignments in all services, or is classroom instruction sufficient? When she is ready for clinical experience, what constitutes an adequate experience? How can a student's assignments be made on the ward so that she will learn those facts or skills or attitudes she needs to learn? To be realistic how can such an assignment be made without disrupting the ward service, for if this be disorganized neither patient care nor student learning will be right. Which content can be taught successfully and economically to large groups in the classroom, which in small group conferences on the ward or in the clinic, which by individual instruction at the bedside? Are there certain areas of knowledge which should be integrated through the courses in nursing? What of the extra-curricular program? Should our planning allow for this? Should there be time for a definite recreational plan, for a student organization, for those aspects of student life which help to mold into well rounded young women those lopsided but normal healthy personalities? Should time be allowed for this aspect of student development?

We cannot say that we in hospital schools will train the bedside nurses, and that the University schools will take care of the leaders for the profession. We cannot say that in a democracy, nor can we say it for the welfare of our own patients. There are 1253 hospital schools of nursing in the country today, and only 171 nursing schools with some type of University or college affiliation. Obviously, we must have leadership coming from the students in the three year schools. Can any one of us, when a girl enters, say "this girl is a leader - this one will never develop such qualities." Are we not obligated under the circumstances to so set the curricula for our three year schools that every student who has interest and ability to do so can build upon her foundation in nursing the advanced preparation she needs to progress to positions of leadership? Have we any right to so plan our programs that students who enter are permanently handicapped in their profession?

The decisions on the foregoing issues, major and minor, will help to determine the length of the curriculum. It is perhaps an unfortunate corollary that the State laws which are set up to protect nursing education also discourage experimentation. For who of us really knows how long a time the curriculum in nursing should require? Even in our so-called better schools of nursing, the existing system of education has demanded that the student nurse carry out procedures with a minimum of basic instruction. It is required, too, that she repeat many procedures long after learning has taken place. It requires experience on night duty, evening duty, and at other times, when fatigue is an obvious deterrent to learning. It expects that the student nurse on graduation, unlike the students in medicine, social work, and allied fields, be ready not for an internship but for practice as a skilled member of the profession. Who of us knows how long it requires to make the student a safe practitioner? How much longer does it require to develop skill? When does learning cease, and when does the student's practice become service?

Many of our curricula have been taught by teachers inadequate in preparation and number. Many of our facilities have not been comparable with the facilities provided for students in other fields of education. How many curricula can we point to that are really good? This is not a condemnation of what nursing education has done, or what has been done for nursing education. I am asking simply, who knows whether the present system allows too much time or too little time? The fact that there are not enough applicants for nursing schools today is not necessarily an index. Perhaps these applicants would like a longer program, if it were a better one. We know that the loss of students from schools with good curricula tends to be lower. Maybe the applicants would like a shorter program. We know that the students who go to the schools of nursing with three years of well planned college preparation often are given only two years of clinical instruction. But these students themselves sometimes agree that they have more knowledge but not as much skill as their sisters in the three year course. Length is not just a matter of calendar months; it is a time to mature, time to learn soundly, time to learn knowledge enough, time to gain skill. If student nurses could have well taught courses including clinical practice planned in terms of broad aims, in terms of student learning needs, in terms of sound educational method and adequate instruction, what could we do about the length?

I have not enumerated all of the issues pertaining to content and length of the curriculum by any means. I have tried to review some of those which are more commonly considered, some which are most obvious. What can we do about them? Years ago, in an address to his students, President Eliot of Harvard quoted the familiar verse "They shall mount up with wings as eagles, they shall run and not be weary, and they shall walk and not faint." He pointed out what seems at first reading that the order of activities in this quotation goes from glorious flight to walking which seems an anticlimax, but that actually it takes more courage, more

determination, more strength, more effort to carry on the smaller duties persistently and effectively day after day. In most of our schools of nursing we have not the staff now necessary to begin a large scale curriculum study and revision. Most of us in the schools are not prepared to do such a study. We cannot soar to the heights of a great study. Neither can we return home and hastily assemble committees and materials to launch, on the run, a plan for immediate study. But all of us can day by day, if we have the understanding of the groups with whom we work, persist in facing the issues which pertain to our individual curricula, and as rapidly as possible and as is practical make the changes.

Flying fits the individual who likes the solo type of pattern. Running leaves friends and co-workers behind, for in that, too, it is a matter of every man for himself. But walking is a companionable activity, a democratic one, for there is time to talk, to think, and to share. Curriculum planning for a school is not a solo job. It is a challenge to be shared by those who have the courage and the strength to walk together towards better nursing care for all who need it.

A YEAR OF SOWING

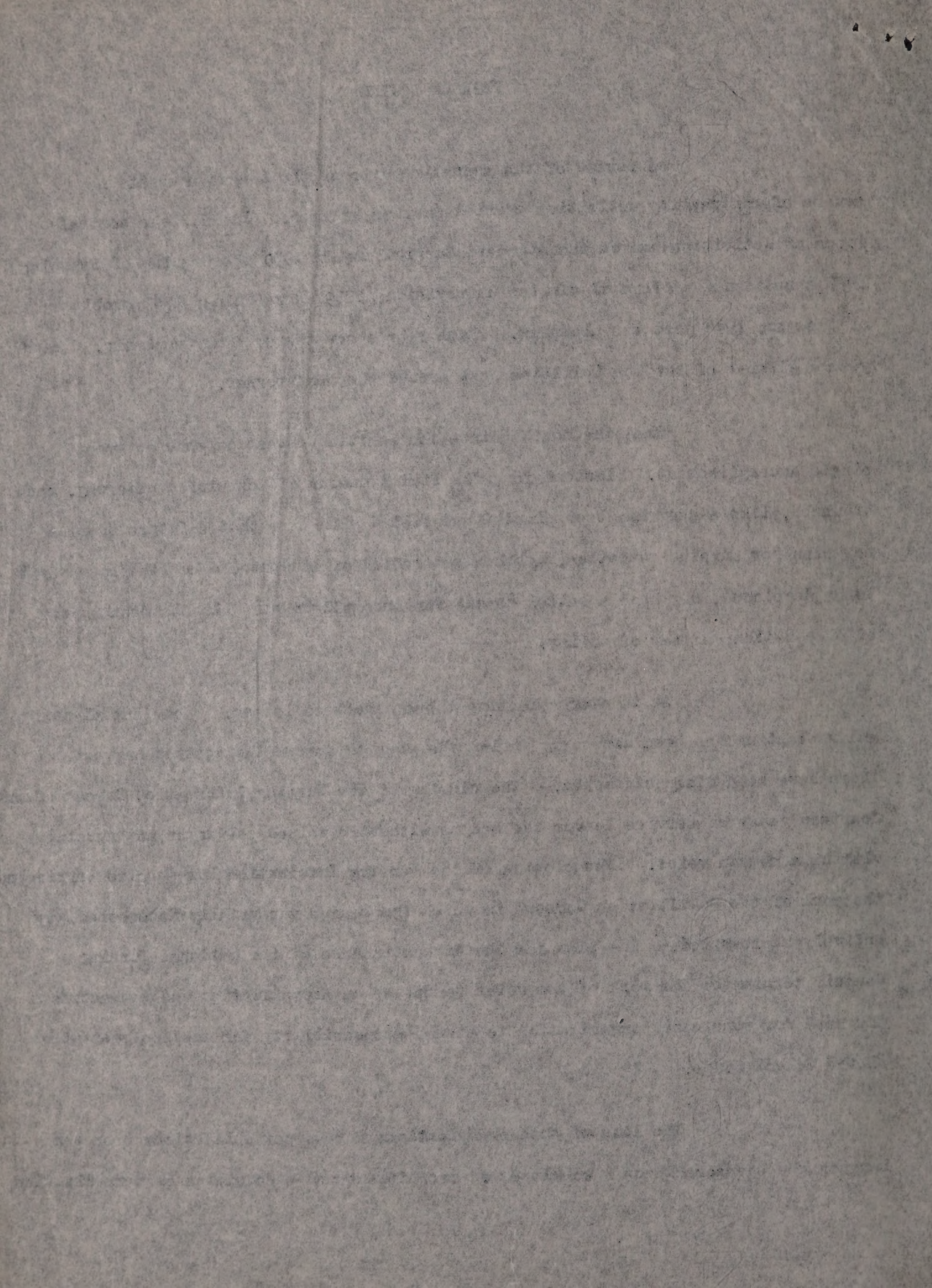
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A review of the annual reports of the League presents a series of contrasting activities carried on year by year. In 1917 the central focus of activities was on the Standard Curriculum; in 1930 the Grading of Schools; 1937 a broadened pattern of curriculum revision; 1939 accrediting; 1943 problems of the war; 1944 post war planning. Each year a new theme, a new emphasis. Each year a glimpse of the possibilities just around the next corner.

The nine months since the Seattle Convention show no great single accomplishment. Instead you will find a number of activities underway, each of which, like a seed has been planted and tilled with care that a future crop, a new plan for nursing education, another generation of students, a health program yet to be developed, may have a better chance for accomplishment. It has been a year of preparation; a year of sowing.

As in every planting there have been losses. Constant planning and replanting has been necessary during the year to assure the desired harvest. There have been disappointments. The closing of the Nursing Information Bureau after fourteen years of service leaves the League without a valued co-worker, and nursing without a common voice. The closing of the Nursing Information Bureau also terminates the work of the Committee on Careers in which the League was vitally interested, and actively represented. The plan for the discontinuance of the National Nursing Council terminates the work of the Joint Committee on Accreditation and emphasizes the need for some other organization to assume responsibility for the implementation of the School Study.

The loss of both organizations throws new obligations upon the League: the sponsorship of a committee on recruitment and a committee on accreditation



for advanced as well as basic programs. To us also falls the obligation to follow the pattern set so well by these two organizations; to sponsor educational projects which are truly joint; jointly supported, jointly planned, jointly implemented, and jointly beneficial. The closing of the Nursing Information Bureau concludes the first broad service in unified public relations for nursing. To Miss Mary Roberts and the Board of Directors of the American Journal of Nursing who had the vision to conceive such a service goes the gratitude of the League for all the support given to our programs and all the assistance given our Committees and Headquarters Staff. Although the National Nursing Organizations are to form a joint committee to collect facts and information about nursing, this will in no way substitute for the Nursing Information Bureau program planned and carried out by a skilled public relations staff under the wise guidance of Miss Roberts. Neither can such a committee present a unified program to the profession or its public.

The closing of the National Nursing Council brings still another era to an end, for with its closing cease the major activities planned to meet the needs of the war and the post war years. Since 1940 the National Nursing Council has demonstrated the power of cooperative action, action of organization with organization, of nurses with nurses, of nurses with hospital and medical association representatives, of voluntary and government agencies. In the Council, the League found understanding and support. To those who initiated the organization, to its officers, its executives and staff members, who served the League as they served the Council, we would record our appreciation.

The School Study, one of the most important projects of the Council is now complete and ready for presentation to us at this Convention. Originally, a unit in our post war plan, this study is of critical importance to the League.

On its recommendations wait our next steps in curriculum planning. In it may be new directions for school organization. For its implementation, you must soon decide what obligation the League is to assume. Soon you must decide how all nursing organizations can be brought together to act upon the recommendations of the School Study.

Soon you must decide whether you want a unification of nursing; whether the recommendations of the Committee on the Structure of the National Nursing Organizations are to be accepted; whether we can in all conscience continue the expenditure of more money, more time and effort, to formulate still another plan; whether nursing is ready yet for unification. At the Seattle Convention the League membership acted upon the report of the Committee on Structure and renewed its directives to its representatives. Since that time members of your Board of Directors have met twice with the Boards of the other five organizations, once in November and once in April. The increased support of all organizations, the growing understanding between boards, the determined effort to find a common ground for agreement has been encouraging. Meanwhile your representatives have met with the full Committee, and served on the various Sub-committees. The progress plan of the Structure Committee has been presented for your consideration at this meeting. What steps shall be taken? How can we assure future support for nursing education, future support of the programs of all the other National Organizations? The plowing and harrowing have been done for several seasons. The germ of unity has been planted. Both germinating seed and germinating idea alike can lie fallow too long to bring forth a successful harvest. What are to be the next steps?

Joint thinking has not been restricted to the Nursing Organizations. There have been three significant meetings this year with hospital administrators and representatives of the Hospital Associations and the American Medical Association.

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In November, the American Medical Association Committee on Nursing invited representatives of the Hospital and Nursing Associations to meet in Chicago. The meeting was given over entirely to general discussion, fact finding, and interpretation of nursing problems which affect hospitals and medical practice.

In early March, the League cooperated with the American Hospital Association in an Institute on Nursing Education for hospital directors and directors of schools of nursing. That the participants might have active group work and free discussion the number of both hospital administrators and nurse directors was limited. To secure representative thinking, applications were accepted on the basis of geographic representation and size and type of school and hospital. The agreement between groups was auspicious, the understanding heartening. I should like to record here the appreciation of the League for all that was done by the American Hospital Association to make this Institute possible; the constructive program, the effective organization of activities, the excellent discussions. It is hoped that some means may be found to make the Institute papers available to all those who could not attend but wish to share in its benefits.

In late March, the American Hospital Association called a meeting in New York. The following were invited to the meeting: representatives of the three Hospital Associations, the American Medical Association which included representation from the American College of Surgeons, the American Nurses' Association, the National Organization for Public Health Nursing, and the League, one of whose two representatives could speak on the problems of collegiate nursing education. This meeting, one of a series to be held, was also a general discussion, a coming together for mutual discussion and interpretation. It was, we hope, the beginning of better understandings.

As this report is prepared, the League is sending representatives to the National Health Assembly in Washington, May 1 - 4. This meeting has been called by Federal Security Administrator, Mr. Oscar Ewing, for the purpose of discussing a ten year health plan for the nation. What this plan will do for nursing no one can yet say. The League has already set forth the principles on which we believe federal legislation for nursing education should be based. The American Nurses' Association which worked with the League and the other nursing organizations as these principles were prepared, is ready to support us if and when legislation is introduced. Nursing stands with medicine, dentistry, and public health, as one of the essentials and one of the shortages in the projected program for national health. That nursing education may be included in the legislation for this ten year health plan seems probable. That the League should have an active part to play in this ten year health plan is indisputable.

Certain units of the League program stand out sharply in the light of these national activities. Guidance to schools and accrediting, that we may help schools with basic and advanced programs to improve. Research studies on nursing and curriculum, that we may meet patient needs, and move forward with medical science in our teaching. Measurement and educational guidance for applicants, that the calibre of the student admitted may produce the calibre of the graduate necessary for the work that it to be done. Cooperative action with other nursing organizations and with the public that the needs of nursing education may be correctly interpreted, and the progressing plans for nursing education sympathetically received.

The National Committees and the Headquarters Staff will report separately to you. They have planted the seeds this year. Now it is the

privilege of all of us, League members and others alike, to till those seeds, that they may bring forth abundant harvests, of better nursing education, of better understanding, of greater respect, of increasing support. This year has been indeed a year of sowing.

RS:MF
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The level at which the educational standards are to be maintained in the postwar hospital will be determined by the combined philosophy of the hospital administration, the medical and surgical staffs, and the nursing staff. No one of these groups either determines or maintains this philosophy alone. It will be the accumulative result of what the hospital can and wishes to pay for education; what beyond the care of patients the administration requires of its nurses and student nurses; why the administration wishes to conduct a nursing school; how much the medical staff can and wishes to contribute to the educational program; what degree of leadership is provided in the nursing staff; how much freedom the nursing staff is permitted to initiate and to conduct a program, which prepares for optimum service today and for progress in the future commensurate with changing social conditions and progressing medical practice.

To maintain best educational standards in nursing in the hospital, the educational program must include all groups, each in turn being prepared better to complement or supplement the other with changing practices. No one of us in nursing, regardless of our duties, can ever consider our education finished. There must be in a progressive hospital an in-service education program constantly in operation, either a program to teach new nursing methods necessary because of new surgical and medical practices; or a program to study nursing techniques in order to standardize, to simplify, to improve, to adapt better to the individual patient's needs or a program to keep the nurse stimulated to give her best care to patients and thereby to help the nurse find greatest satisfaction in her work. It include all graduate nurses in the hospital in this educational program for better nursing care regardless of their function. Be they administrators, teachers, supervisors, staff nurses, the ultimate objective of their planning is the patient and the community health, the end results of their efforts better mental and physical nursing and better health for all.

Such a program for the graduate nurses would not be a time consuming plan. But it should be continuous and carefully planned with consideration of individual nurses needs, the contribution of the nursing service to the administration and medical practice, and most especially to the needs of the patients. A heterogeneous, unstable, nursing staff will require a planned orientation program to adjust to new hospital and medical practices; a homogeneous, stable, nursing staff will require a stimulating program, informative of the newer developments in nursing and allied fields. Today, most hospitals need both types of programs given simultaneously.

The educational standards for the school of nursing must be more carefully stated in terms of both educational and nursing goals, for this program is not a supplementary experience but a basic education. In the past, hospitals may have established schools of nursing with the intention of supplying their own needs for graduate nurses and nursing service. But social forces today have made the nurse an essential health worker outside as well as inside the hospital. Whether their original objective or no, hospitals now find themselves with the responsibility for giving a broad general basic education in nursing which can keep pace with progress in medical science and with workers who are educated in frankly educational institutions controlled and financed for that purpose alone.

Because preparation for nursing is an educational process certain standards are set for us and over these we have little control.

1. Good recruits are necessary to make good nurses. I shall not stop to define a good recruit - personality, health, native intelligence, and necessary educational requirements are familiar to you all.
2. Competent young women choose nursing today to secure an education, and so expect an education which will prepare them for life and work beyond the hospital as well as in it.
3. This competent young woman wants opportunity for personal growth as well as preparation for nursing - in short she wants an education comparable to her sisters in teaching, library science, home economics and the like.
4. To provide a situation adapted to education, opportunity must be assured for the student nurse to carry on those activities essential for her learning needs.
5. In a truly educational situation, the hospital cannot depend entirely upon students for the nurse service; this must be provided by general staff nurses and supplemented by student nurses and various auxiliary workers.
6. Learning time varies with the complexity of a procedure and does not require indefinite repetition. Repetition beyond the time required for learning is service contributed by the hospital and constitutes a monetary payment for maintenance and education.
7. Education for nursing like any other type of education is costly and the student should not be expected to pay for it entirely either in tuition fees, or in tuition fees combined with service to the hospital.

To have high educational standards there must be good admission standards, a sound curriculum, educational facilities to implement the curriculum, practice fields which will furnish adequate opportunities to learn to nurse, a student personnel program which will assure the student the proper health supervision and care, right living facilities, a social and recreational program suited to a young woman who wishes to live fully and must learn to manage her own personal life successfully, personal guidance suited to her own peculiar needs, and finally, a faculty adequate in numbers and preparation to put the curriculum into action.

The admission standards should insure admission of young women capable of working constructively with other professional groups in the hospital, doctors, dietitians, social workers, and other therapists. Of all these groups, the student nurse is alone the one admitted without at least a part of her professional education. To compensate for her youthfulness, to assure her ability to read and analyze materials, to express herself clearly, to make wise judgments, to understand and manage people, the admission requirements should include two years of general college study beyond high school.

In most schools the curriculum must be broadened, either in practical experience, or both experience and instruction. For years nursing curricula have included instruction and experience in 4 basic fields - medicine, surgery, obstetrics and pediatrics. Now these four fields alone are not enough. For example in psychiatric nursing many schools have given theory only. In a country where important psychiatric manifestations are increasingly found with medical and surgical conditions, the nurse who is to give best service to both patient and doctor must be equipped with more than a few lectures on psychiatric nursing. I emphasize the need for ward experience in psychiatric nursing in addition to classroom instruction because nurse educators are convinced that to learn nursing books and lectures are not enough. To learn nursing one must learn by nursing a patient.

Into this broader curriculum should be integrated a more thorough knowledge of the community from which the patient has come to the hospital, the social and health factors which influence the individual and his disease condition, the knowledge the patient and his family need to care for the patient on discharge home, how he may be cared for in his home, the community facilities other than hospitals available for health care. I shall not designate this as public health nursing, because it is first and foremost a part of good general nursing care. When pursued as a special field by the graduate nurse, we do call it public health, but when a knowledge of these factors can be brought by the hospital nurse better to understand her patient, better to observe his total needs, better to recognize and to refer problems to doctors and social workers, better to help the family accept his incapacities and better to prepare for his further care at home - that is nursing - but an aspect of nursing unfortunately too often forgotten in the narrowness of our hospital visions.

Curriculum study should be continuous and each field broadened as progress is needed. Facilities for good teaching and learning should be furnished for the schools, adequate classrooms, well equipped laboratories, well supplied and supervised libraries. These need not be extravagant but they should be inductive to right learning, and to economic learning. The faculty - one almost hesitates today when schools are still lacking literally thousands of teachers and supervisors. The faculty should be adequate in number and preparation to teach the curriculum, including a large enough number to work and teach at the bedside, to help the student bring all of her learnings into use in the care of the patient.

The personnel program in the school of nursing is not new but like most of the units of our educational program has grown from a program imposed upon the student for her own good into a program in which the student participates because she sees the program is developed around her needs. The large school should be allowed a trained guidance worker with a plan for cooperative faculty action; the smaller school needs 1-2 faculty with some preparation for student personnel work. A successful program will help to save unfortunate drop-outs of good nursing material, and unfortunate retention of misfits.

As I have considered the standards which nursing should set for the post war I have been again acutely conscious that each one named could not be implemented effectively without a well planned and generous budget - Curriculum, facilities, faculty, student personnel program - each one may be costly. So I am brought again

to the principle so often reiterated in nursing, but so seldom put into effect, nursing like other systems of education must have a sound economic basis. How this is to be achieved I am not attempting now to say. It should not be financed by student services; it should not be financed by government, if there is to be concomittant government control; it cannot be financed from funds given for the care of the sick beyond the amount honestly warranted. But ways have been found to give relative economic security to other fields of education for public service, and nursing, an acknowledged community need, should be taken into the more secure economic fold and then, and then only can we maintain sound standards in nursing education.

GRADUATION ADDRESS

NEW ENGLAND HOSPITAL FOR WOMEN AND CHILDREN

October 28, 1948

GRADUATION ADDRESS

It is a great honor to speak at the Graduation Exercises in a school where modern American nursing began. It is also a great privilege to share these Exercises with you in the Diamond Jubilee Year for American nursing, a year which honors an illustrious nurse, the first nurse Alumna of the New England Hospital for Women and Children.

September 1, 1873, Linda Richards was given her diploma. About her graduation she writes: "How well I remember the morning after my first year closed. Dr. Dimock sent for me to go to her office and very quietly, and with a few well chosen words, handed me my diploma" The contrast in that simple Graduation Ceremony held for Linda Richards seventy-five years ago, and your Exercises tonight emphasizes the many contrasts between her preparation and yours: the contrasts between the conditions under which she worked and the conditions you will meet as you enter the field of graduate nursing. Let us picture the nursing care required in 1872 when Miss Richards entered the training school. We remember that Lister had not yet developed his theory of antiseptics, so there were no aseptic dressings to be done, no surgical dressings to be made, no instruments to be sterilized, no medical aseptic technique to be carried out. Roentgen had not yet given the secret of the X-Ray to the medical world, so there were no preparations for patients having X-Ray, or after-care of patients having X-Ray therapy. Anesthesia was in use, but the science of anesthesiology was not yet sufficiently developed to require long and careful preparation, or after-care of patients. The hypodermic syringe, the stethoscope, the blood pressure apparatus, and even the clinical thermometer were not yet in use on hospital wards. Clinical charts, if kept at all, were usually kept by the doctors. The respirator, the oxygen tent,

the inhalators, the various types of suction and drainage now in use were then unheard of. Special diets were not ordered. Baths and simple rubbing made up the physiotherapy. Occupational therapy, when it existed at all, was merely a matter of furnishing simple and common-sense exercise or diversion.

Nursing care for the most part consisted of feeding, bathing, and rubbing. Medications were few. Old medical records would appear to indicate that the nurses must have spent many hours making poultices of flaxseed, onion, and ginger. Heat was also applied by the mustard pastes, stupes, and hot flannel fomentations. Application of leeches, blistering cantharides, dry and wet cupping were common. Nurses often were busy washing, ironing, and rolling bandages, or padding Pott's splints. They made numerous teas, such as flaxseed, anise seed, sage, balm, camomile, thoroughwort, spearmint, and wormwood. Doctors were few. Other workers coming to the wards were uncommon. The woman who cared for the patients at the bedside was both nurse and ward housekeeper.

It is not surprising in such a situation to find the curriculum a short, simple plan, which evolved from the needs of students, doctors, and especially patients. You will remember the twelve lectures that Linda Richards describes as her class program. The ward assignments, too, were simple. Three months of medical wards, three months of surgical wards, three months in the maternity department, two months of private duty, and one month of night duty.

It was to be expected that Miss Richards, upon her graduation, would go immediately into some form of administrative work. She had really only two alternatives, private duty and administration. There were no staff nurses, for the important field of institutional bedside nursing by graduate nurses is a modern development. There were no opportunities for her to enter

teaching, for there were no other schools of nursing, and in her own school the teaching was done by doctors. Public Health Nursing positions did not exist. To make a place for herself it was necessary that Miss Richards develop a new field of work. By force of circumstances, she and her contemporaries were pioneers. Some, to be sure, were pioneers in a very small way. Some, like Miss Richards, saw the larger need, and led the way for the less imaginative and the less able.

Now, tonight, what of you - the graduates of her Diamond Jubilee Year? Can you, too, be pioneers? Or are the satisfactions from such adventures closed forever to you because you came too late in the history of nursing in America? Let us consider first what makes a pioneer. Must one be born in primitive times in order to find opportunities to pioneer? Must one live in an unexplored country where there are yet undiscovered territories, and new paths to be broken? Must one have special training which tells how to lead the way? Or is it merely a matter of being the type of woman who having recognized the need will set her goal in terms of her opportunities, her abilities, her training, and her obligations? Unstimulating indeed would be the outlook for the youth of America if all the new fields of service had finally been discovered, and if the end of scientific research had been reached. The way of the pioneer of 1948 may bear little similarity to the way of the pioneer seventy-five or a hundred years ago, but the zeal, the devotion, the desire of the pioneer to give to the world, or to his own small community, something which will bring opportunity for better living, greater joy or comfort, or more physical or mental well being, has not changed. Surely the year 1873 did not present any greater opportunities than you may find in this year of 1948. Never before has there been more urgent need for nurses than today. The Commission on Hospital Care estimates that an added 195,000 general hospital beds and 45,000 beds for the care of the tuberculosis patients are needed. The extension of hospital services into the community promises to stimulate

the development of all types of follow-up services, immunization programs and clinics for the prevention as well as for the cure of illness. Public health services must be greatly expanded, if all citizens are to have equal opportunities for healthful living. Voluntary health insurance plans are growing. Government programs for increasing health services are constantly being developed. Nursing, with medicine, promises to furnish preventive as well as curative care. New visions of a healthier and more effective nation lie before us. Never has there been greater opportunity for the graduate nurse, whether she wishes to work in the institution or in the community; whether she wishes to practice as a generalist or a specialist. The locality in which a nurse lives makes little difference today. There are opportunities at home throughout the United States and abroad in other countries. Health is now an international problem.

It would take many pages to describe the program of training you have been given here at the New England Hospital for Women and Children. No single paragraph could include the outline of your ward experience, of the list of your classes. Your curriculum has been set by experts after long study and experience. It is recognized for licensing in this State and in many other states. It will furnish you not only with a basis for beginning your practice of nursing, but will give you as well the basis for postgraduate education unknown in Miss Richards' day.

Different as may be your programs of study and your opportunities for work, there remains one important factor common to you who graduate today, and to the women who graduated in 1873. I refer to your obligations as nurses and as citizens wherever you may live. What is to be your attitude toward your work? Will you seek only what you want to do, or will you choose what needs to be done? Will you give day by day what is easiest to give to your nursing, will you choose the work which gives the most, or will you give the

services that patients need to have? Will you nurse by the clock or by the calendar, leaving your position which needs you day after day when the clock strikes, or starting off for the green fields of the camp nurse when the calendar turns to June or July? I would not exclude your needs as young women for rest, recreation, normal companionship, or personal advancement. But taken as the most important factor in your lives, these will not bring satisfaction or flavor to your work. Taken as a kind of frosting after work well done, you will have a double reward: the deep satisfaction of your service to others, and your own personal achievement, and the joy of recreation relished to the full because it is built upon the peace of mind and serenity which such satisfactions bring.

Miss Richards wrote "it meant very much to me - this being a graduate nurse, and the only one in the country. I took my diploma and went to my room for a few minutes of quiet thought. I had been trained for hospital work. I would continue it if God gave me health and strength. This, was my determination."

Graduation should be a time of determination; a time to determine one's obligations and one's goal. What does the acceptance of your diploma mean to you? To be sure you have worked hard to earn it, but it is not a gift - it is yours by virtue of what you have learned to do. If you stop to consider why there are schools of nursing and why people, doctors, nurses, and others, have worked hard to help you to learn, the significance of your diploma may be more clear. The operation of professional schools to prepare workers for community service is a public responsibility. The Trustees, the women who manage the affairs of the New England Hospital for Women and Children have assumed such a responsibility. You are the product they have prepared for service to society. Can you not, therefore, see in this diploma of yours the same deep significance which Miss Richards saw in hers? You, I, the

graduates of all nursing schools have an obligation, because we elected to be graduate nurses. Each of us in our turn accepted an appointment in a school of nursing. For each of us society expended time, money, and thought - that we might be educated as nurses - to serve. What is your determination? What is to be your goal?

If you are to remain in nursing what will you do? If you are to marry and build a home, you cannot shed this obligation to society, because you are a nurse as well as wife and mother. What then will be your goal? If you are out of active nursing, and cannot return to serve full time in hospitals or public health agencies, how can you use your nursing effectively in your own community? Will you nurse the neighbor next door? Will you give a few hours a week at the local hospital when the hospital needs your help? Both the nurse who marries and the nurse who plans a career can use her vote to secure the best health services for your community. Both can serve in Parent Teachers Organizations, using their knowledge to make the school a better and safer place for the children of the community. Both can be members of their Alumnae Association to work for the betterment of their school and hospital. Both can help with the local State and national nursing organizations in order that the voice of nursing may be strong and clearly heard.

As students in the school of nursing you have had many opportunities to keep in touch with what is new and what is needed in nursing. As graduates you will be away from this source of information. No one will hand it to you. No one will tell you what to read. It will be your turn to find out for yourself, to keep in touch with the situation. Your Alumnae, your local, State, and national nursing organizations, your professional magazines will then be your source of information, your stimulus, your opportunity to learn of the new discoveries in the medical sciences, the new

developments in social relations, the new trends in nursing. These will give you your opportunity if you will take it, to share with Miss Richards and her co-workers the joys and satisfactions of the pioneer who helps to chart a new course, or helps to explore some small, but new or yet undeveloped, territory.

Dear Seniors:

"Today is Weight Day." Do you remember that familiar sign which greeted you at frequent intervals during your student days? Do you remember how we charted your weight month after month because we felt a great responsibility for your well being?

This year of your graduation you will join a long and distinguished line of nurses who have gone forth from the School for three quarters of a century. These women have gone to work in every state of this Country and in almost every other country in the world. They have practiced in hospitals, homes, schools, industries. They have nursed the young, the aged. They have worked in large city hospitals and in the lonely countryside. They have taught nursing to pupils in distant lands in many languages.

Have you ever stopped to think of the place you will hold in the family of the M. G. H. School of Nursing? Have you ever considered the difference between your preparation and that of your predecessors of ten, fifteen, or twenty-five years ago? Have you ever weighed your obligations and responsibilities against the broader preparation you have been privileged to receive? Today is your commencement; today is weight day.

This time you will do the weighing. The record will read not in pounds but in responsibilities. The weight will not be for your physical well being. Today you will weigh your future. There will be purpose and achievement to balance against purposeless wandering; service to others to balance against personal gain; judgment, determination, courage, against ease and indulgence; openmindedness, cooperation and understanding against intolerance and selfishness.

It will not be a simple matter to record this type of growth on charts. Mere dots and squares cannot show mental and spiritual development. Lines cannot indicate the sense of obligation or personal and social responsibility well met. But, nonetheless, the growth will be evident for there will be for you the faith of patients, the trust of co-workers, the belief of friends, and respect for self.

From the School, congratulations on your past achievement. From the Faculty, best wishes to you. From your sister alumnae, a welcome into your chosen profession. From us all, a promise of a helping hand.

Today is commencement. Have you weighed in yet senior?

11/25/47

RS:EF

3/12/01

BETTER COORDINATION OF HOSPITAL SERVICES FOR THE
CARE AND TEACHING OF THE PATIENT

A NURSE'S POINT OF VIEW

~~For the purpose of this discussion I should like first to discuss nursing.~~
Unfortunately, I cannot be as clear in my definition ^{of nursing} as Florence Nightingale was in the subtitle she chose for her book called "Notes on Nursing - What It Is and What It Is Not". Like others today I cannot be sure whether we know just ^{what we shall know until the results of current studies on nursing} what nursing is. When there was no social worker, no dietitian, no housekeeping ^{functions are complete} department, no laundry supervisor, it was a simple matter to define the functions of the nurse. She combined the functions of many present day hospital workers caring for the patients' environment and giving the care not considered the responsibility of the doctor. The doctor, the hospital superintendent, and the nurse were the hospital. Gradually specialists of many types were added to do better the work the nurse was neither prepared nor given time to do. With these additions the hospital service to the patient was greatly improved. But with the advent of these workers came many problems for the hospital administration, the doctor, the nurse, and most important of all this improved service brought heretofore unrealized problems to the patient.

Rather than define ^{with the word nurse} nursing, I shall ^{restrict my discussion to hospital nursing and} divide it into two areas of activity: nursing service and patient care. Nursing service includes the maintenance of the patient's environment, the ordering and care of supplies, the provision of facilities and equipment needed by the doctor and the nurse, or other professional workers in caring for the patient. Nursing service may also include the assignment, management, and teaching of the personnel involved either in furnishing the service or in giving the actual patient care. Nursing care on the other hand is the activity actually carried on directly with or for the patient.

The fact that the nurse actually gives two types of service in the performance of her function requires that she coordinate her activities with two different groups of workers in the hospital. First, there are those other departments which also give services essential to the welfare, safety, and medical care of the patient, such as the pharmacy, the store, the maintenance department, the housekeeping department, the laundry, the laboratories, and the like. With these departments the nurse must work and maintain the proper inter-group relationships if the patient is to be physically comfortable, free from annoying noises, or sights, warm, clean, supplied with medicines and the equipment his care requires. Second, there is the group of workers who like the nurse contact the patient directly, such as the doctor, the dietitian, the social worker, the physical therapist, the occupational therapist, the laboratory technician. With these the nurse must also work and have constructive relationships if the care of the patient is to follow a well ordered plan in which no one element conflicts with or negates another.

The nurse occupies in the hospital what at times is an enviable position. She is always with the patient. Other departments and professional workers come and go, but throughout the twenty-four hours for seven days a week a nurse remains. In the absence of the maintenance department she must know whether the electrical equipment is safe. In the absence of the doctor she must know how to answer the patients' queries, and if necessary modify the treatment until the doctor can be reached. When the dietitian goes home she should be able to meet the situation if questions pertaining to food arise. She can help or hinder as she is prepared and as hospital and medical policies permit her to function. Moreover this nurse is with the patient after doctor, social worker and others have completed their daily calls. She cannot help but observe the affects on the patient of the many

workers who come one after the other, each with his or her own special interest to pursue, unaware often of the never-ending stream of workers and the strain this constant adjustment to many people may bring, not realizing that between doctor, social worker, dietitian, laboratory technician, there is no time for the patient to rest, or even to make the adjustment to one before the next appears; no time to gather strength after the pain of the dressing to have any interest in the tray which immediately ^{arrives} ~~appears~~.

Now all of this conglomeration of workers are by no means from other departments. The nursing department itself has often enough workers today to confuse the patient. In the effort to meet the ^{demand for} ~~shortage of~~ nurses, auxiliary workers have been added; the licensed attendant, the trained-on-the-job-aide, the orderly, the ward clerk, the ward helper, the volunteer. Tasks have sometimes been assigned on the Ford factory system, because it ^{has seemed more} ~~is more~~ efficient in terms of clock hours to have each worker perform one special task. One passes trays, one fills pitchers, one makes the bed, one gives the medicines, etc. The result is, of course, that the nursing department adds its workers to the never-ending stream going into the patient's room. One patient on a gynecological ward floor was kind enough to note on a slip of paper whenever someone came into her room to carry out a procedure, visit, or clean. From 7 A.M. to 7 P.M. this patient was approached for one purpose or another 44 different times. As we think about this patient's adjustments it should be noted that whether from exhaustion or writers cramp there are no notations between 2:30 and 3:50. It seems probable that asleep or awake someone must have at least looked into her room during that hour and twenty minutes. It seems significant enough to take time to list the various individuals who visited this patient: head nurse and assistant, nurses on the floor; two doctors; hospital aide; ward helper; ward clerk; social worker; librarian; medical student; volunteer; Red Cross Aide; ward maid. I am glad to report that in addition to these 44 visitors the patient's husband also arrived at 6 P.M., and also would like to

state that this is not an exaggerated or inflated example. Obviously, someone on the staff should be giving consideration to the patient under such circumstances.

There is ^{The} need for coordination at the patient's level. ^{is evident} The doctor is naturally the person who might effect this coordination, but he is on the floor usually but a short time. We might choose next the head nurse, who being in charge of the floor could plan a schedule for the patient to allow ~~for~~ the rest a hospital stay should provide. But, if we consider the situation of the head nurse, she like the patient is meeting and adjusting to an unending stream of professional and non-professional workers. Coordination cannot be brought about by one worker. There must be time to think and plan with all concerned. Consider the position of the head nurses on two semi-private floors. The capacity of these floors is 37 beds each. For most of the week all beds are occupied. On an average day, by actual count, on the medical floor from 7 A.M. to 7 P.M. 70 doctors came to see one or more patients; 41 of these doctors came before one o'clock in the afternoon; 15 came between 10 and 11 o'clock in the morning. On the surgical floor there were 55 doctors visits; 31 of which were made before one o'clock. Many of these doctors changed orders for their patients.

To carry out the doctor's orders, give the nursing care, and maintain the floor service, these head nurses had staffs composed of workers of widely varying backgrounds, as well as responsibilities: graduate staff nurses: third, second, and first year student nurses: licensed ^{R.N.} attendants; hospital aides; orderlies; ward helpers; ward clerks; It was necessary to send patients to X-Ray and on one floor to the operating room. Laboratory technicians came from several ^{different} laboratories to carry out different procedures. The dietitian needed to discuss certain patients. A few words were needed with the housekeeping department

supervisor. Certainly, there is need for coordination of activities which affect patient care at the head nurse level, if that care is to be satisfactory, if the patient is to feel secure and happy in his care and if the personnel are to do their best work and find satisfactions in their jobs.

We in nursing have been increasingly concerned over this growing complexity of the hospital's services, and its affect on the care of the patient and the ^{effectiveness} efficiency of the personnel. As a first step toward a solution of the patient's dilemma in respect to nursing care, we have tried to coordinate nursing care through the use of a so-called "bedside care team". In this plan a graduate staff nurse or a senior student as team leader is assigned the responsibility for a group of patients. The head nurse and the team leader review the plan for the patients' care, including medical and nursing care. It is then the responsibility of the team leader to assign each member of the team to give those aspects of the care for which they are prepared, to work with each member as the situation demands, to supplement the work of the auxiliaries, to give those aspects of the care the auxiliaries are not prepared to give, and to so manage the situation that the patient feels secure in his care, and that the nurse leader of the team knows him as an individual and sees and understands his needs, emotional as well as physical.

But this team answers only a part of the problem on the ward. A second group is also necessary. Perhaps we might call this a planning team, composed of doctor and head nurse, with dietitian, social worker, physiotherapist and occupational therapist, as they are active in the patient's care. This team in which the doctor should be the leader should make the over-all plan for the patient's care with the patient's comfort and welfare as the central focus, and should coordinate all ward activities in such a way as to make clear to all concerned that the purpose of the ward staff is a patient centered one.

But coordination ^{for better patient care} cannot end on the patient floors. These two teams will succeed or fail as the attitude of the chiefs of the medical and surgical staffs, the hospital administration, the director of nursing, and other department heads understand each other's problems and carry on coordination at top level, through comparable planning sessions. If hospital policies are determined after free discussion and consideration of their affect on all departments, if nursing and other departments affected are notified of pertinent changes in research activities, or new plans for patients in time to prepare for the changes before they occur, if when there are conflicts, errors, or omissions involving nursing, these are talked over constructively with the appropriate officer of the nursing department at an appropriate time, then the floor teams may be expected to succeed.

The same plan holds true in respect to other services necessary to maintain the safe and attractive environment for the patient. Perhaps in this respect the department head conference with the hospital director becomes a coordinating ^{or a management team} mechanism. Certainly, the attitudes built in these sessions by the hospital administrator cannot but succeed in paving the way for good group relationships, at the department head level, and the directors of the pharmacy, personnel, store, and housekeeping departments will find the way paved for coordination with nursing on all levels.

^{Nursing as conceived by the nurse today is more than dressing, medication}
^{All these}
~~The problem of improving the teaching of the patient seems~~ to require more ^{nurturing} than coordination of services. Basic to this question seems to be a fundamental disagreement as to the function of the nurse. The doctor of public health, the nurse, and the patient, too, see ^{what or elements of what} this as an important responsibility of the nurse. The ^{hospital} doctor may or may not agree that ~~this activity~~ is rightly included in nursing. ^{For example,} or if the doctor acknowledges that the nurse may teach, he often does not agree with his medical co-workers on the content for which the nurse should assume responsibility. No nurse would presume to question the fact that the doctor does a great deal of teaching. But many patients and nurses will

^{general hygiene measures}
^{There is teaching}
^{rehabilitation}
^{support, preparation for care in the home}

tell of instructions given at a time when emotions or other factors distracted attention from the teaching, or when all of the doctor's discussion could not be absorbed at one brief visit. It is, therefore, natural that the patient may wish to think the instructions through with the nurse who has longer to spend at the bedside, or who arrives at just the right moment to talk. The nurse also can easily have contact with the visiting nurse who can give her necessary information on the home situation in which the patient must continue his care. The nurse plays a large part in the referral ^{plan} form sent on the patient's discharge to the Visiting Nurse Service. She sees the notations of doctor, dietitian, and often social worker on these forms. Gaps in the preparation of the patient for discharge must be recognized, discussed with the doctor, the visiting nurse, and the patient. Surely the nurse should be trusted with the proper safeguards to carry on a practical plan for teaching *for continuity of care for* the patient when this is necessary. Basic to such differences of opinion lie lack of understanding of the nurse's situation, preparation, ability, interest, and intent.

In nursing we are beginning to teach our students in their formative years to work in teams with the auxiliary workers to the end that on graduation the nurse knows the place of each worker, and respects each member of the team for his or her contribution.

Is it not time that more of the students in the various professional groups, contributing to the patient's care, also learned as students to work together and to respect each other's contribution? Could the medical student not benefit by being a member of the ward team - not as the substitute for the interne to give orders - but through well planned clinics ^{only} or rounds to participate ^{+ others} with student nurse, ~~licensed attendant and aide~~ in such a way as to see and appreciate the place of all in the patient's care? *Could not the resident in hospital administration sometimes share with doctor and nurse ^{with department heads} so that he too might realize the potentialities for group action while he is still in the student period.*

The nurse does not wish to assume the functions of the doctor or ~~any~~
~~other professional worker.~~ *the hospital administrator* Her hands are already full to overflowing.

What she does want is to be given understanding cooperation which will enable her to contribute her full share to the patient's care, his physical and emotional adjustment to his illness, to the hospital surroundings, to his treatment, and finally to share in the preparation of the patient for his return to his family where he will recover, or with help will rehabilitate himself successfully. *And in return she hopes to give the understanding ^{support} which will help to bring united action.*

NEW ENGLAND HOSPITAL ASSEMBLY

Section on Nursing

Wednesday, March 28, 1951

Better Coordination of Hospital Services for the Care and Teaching of the Patient

Administrator: Dr. Martin Cherkasky, Director
Montefiore Hospital
New York, New York

Advances in science and civilization bring with them increased complexity and specialization. We always weigh the advantages to be gained out of increasing complexity against the additional hazard which is introduced. Every new gadget in your car increases ease of driving, comfort, or safety, but at the same time includes the possibility of another device which can break down or which needs to be serviced.

This problem is present and serious in relation to the care of patients in hospitals. The modern hospital epitomizes the great advances in medical science. It contains the laboratories, machines, techniques, and professional skills which have enabled us to make such great strides in the prevention of death and disability and in the curing of disease. All this progress has not been made without creating problems. The question we must answer is how we can bring to a patient all the advantages of medical science in a coordinated and integrated manner which will assure that the benefits he gets from such care is not lost by the manner in which it is given. We must develop an understanding that human beings are social beings and more than just a conglomeration of organs and systems. This must be constantly borne in mind if the maximum effect of all the skills and techniques which we have developed are realized.

It is a common failing in many institutions, and I might say, possibly even more among the most highly scientific, that while the doctor on the service may know everything about the patient's blood chemistry, electro-

cardiogram, pulse rate and x-rays, were you to ask the same doctor what kind of a man this was, what kind of a family he had, what kind of life he came from, the doctor would not only be totally unaware of these factors but I am afraid that in many instances he would not understand the importance of these factors in relation to the adequate treatment of the patient.

To provide the proper care for hospital patients, we need the physician and in fact, many kinds of physicians such as the cardiologist, the internist and the surgeon for example, and we also need nurses, social workers, recreational workers, occupational therapists, dieticians and others. We must, however, bring the skills of these professional workers to the patient in a manner which recognizes that while different services are required, the objective is to serve a whole person.

In our Home Care Program at Montefiore Hospital we have demonstrated the practicability of the team approach to patient care and all patient care is directed to the total needs of the patient by creating a team of health workers. This philosophy and program can be applied to in-patient care as well.

It is quite discouraging to see in so many of our institutions that the doctor, the nurse and the social worker, while they are quite pleasant to one another, really seem to feel that their jobs are quite apart. As a matter of fact, particularly in relation to the nursing field, it seems to me that this split between the doctor and the nurse has grown wider and wider in the past few years.

How can we solve this problem of bringing personnel together in a team approach? Well, while I am supposed to talk about the better coordination of services in hospitals, I think it is important for us to recognize that services are rendered by people, and that a worker's training, to a large extent, determines how he functions. In every conference which deals with

hospital or medical care we constantly hear the phrase "we need better education." Ultimately, to provide the kind of coordination of services for the benefit of the patient that we are seeking, we may have to have important changes in methods of professional education. Each worker will have to be educated to recognize the need for and the contribution of other workers. The physician, above all others, is the one who must accept the philosophy of the team approach, since in our culture and society when you talk about health, when you talk about disease or talk about hospitals, the people always think of the doctor, and he must be convinced that this is the proper method of patient care before we can ever hope that it will be accomplished.

There are, I am sure, many administrators and many physicians who will say, "why, of course, social service is an essential part of hospital care, and, of course, a patient is a social human being", and yet I wonder whether this has not become more of a proper thing to say than a real belief.

In speaking to a leader in the field of hospital administration the other day, I made this comment, and said that it was my belief that if we came to hard times many an institution would give up its Social Service Department as a luxury it no longer needs. He commented that I didn't have to wait for harder times, this had already happened in several of our leading hospitals.

What is the problem? What's wrong? The answer is that while the physician has been trained that the heart is essential to the life of a human being and he knows that when he sees a patient short of breath or with some cardiac irregularity, he needs the help of a cardiologist or an electrocardiographer, he unfortunately has not learned and has not become aware of the importance and implication of social factors in relation to health and disease, and to many physicians the social service worker's sole task is to determine what the family income is, what can they pay to the

hospital, and to arrange for discharge.

The part which the nurse can play in patient care has likewise been handicapped by a misconception as to her function, with the prevalent belief that her job is primarily giving the the patient a bed bath or a hypodermic. As a matter of fact one nurse said to me, "every time a physician looks at a nurse, he sees a bed pan." The nurse's contribution to the care of the patient is, or certainly can be, greater than just being the physical skills which she brings to the patient. She can provide him with support and guidance and her observations, warmth and understanding are all important ingredients in the care of the patient. For the nurse to work well with the doctor and with the social worker, she must in her training have developed an understanding of the skills, the knowledges and techniques which the doctor and the social worker can bring to the care of the patient. I am quite sure that I have made more than clear, that fundamental to a solution to the problem of service coordination in hospitals is adequate professional education. However, I think at the same time, we must work with the doctors, the nurses, the social workers and others who are today caring for their patients. The administrator must himself develop an awareness of the patient as a human being, and then with the help of other interested staff members, he must arrange for all concerned with patient's care to sit down together and discuss the patient and his problems.

Dr. Rusk, in his rehabilitation center, has done an outstanding job in this regard. When a patient, who cannot walk because of an injury, presents himself in Dr. Rusk's centre, he is evaluated not only physically by the physician, but he is evaluated by the social worker, the nurse, the psychologist and the rehabilitation worker. They develop a picture, not of a man with a neurological lesion, but of a man with a neurological lesion who has a handicap and who has needs and wants, hopes and resources, and the team

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utilize this knowledge to rehabilitate the patient more quickly and effectively.

You all know the patient with a coronary occlusion who as soon as the acute period is over is eager to get back to work and normal living. On the other hand you probably also know the patient with a coronary occlusion who never wants to get out of bed, who never wants to walk and who, if allowed, to depend upon his own devices, will be a permanent invalid.

A proper team approach and evaluation will uncover the reasons for the reaction of these patients and provide the means for the kind of therapy which will return them both to useful living. Even in such simple things as talking to the patient about what his disease means, the fact that the doctor and the nurse do not discuss the matter, will result in each one of them presenting the problem to the patient or his family in a different manner, causing fear and apprehension.

In Summary:

I have not attempted to outline all the services which the modern hospital has to give to the patient both in care and teaching, but I have tried to indicate that a patient's needs are multiple, and that while we must use different personnel to meet these needs, we will not be doing the best job for the patient unless we develop devices to bring professional people together so that they each will better understand the problem of the patient and so that they will complement one another in their work with the patient.

To arrive at this desirable state requires more adequate education and orientation of the physician and other health workers. However, there is much that can be done in institutions today to follow this idea of coordinated and integrated service for the benefit of the patient. Of primary value is the development of a group approach to the patient. This will result in the professions developing an awareness and mutual respect for each other which is essential for the development of a team.

To develop coordinated services for patients we must recognize that while it may be convenient to break people up into small compartments, unfortunately people are just not built that way.

THE NURSING DEPARTMENT

A PROGRESS REPORT TO THE STAFF

Where are all the graduate nurses? What has happened to our supply? What is the Nursing Department doing about this shortage.

When so much is being said about the need for nurses, it may be a surprise to many members of the M.G.H. family to learn that the Hospital employs almost as many graduate nurses today as at any other time previously, except in the spring of 1950. These nurses will not be found on all the wards, but they can be found in the Blood Bank, the Intravenous Service, the Central Supply Room, the Operating Rooms, on the Research Ward, the Psychiatric Ward, the Isolation Floor, Bulfinch 3, on four floors at the Baker where students are not assigned, and teaching in the School of Nursing. Six graduate nurses will be found covering the assignments which five carried before hours were reduced from fifty-two to forty-four a week. There will be three night nurses assigned to night and evening positions filled by two before patient service was accelerated by early ambulation and discharge. But the graduates are here. The situation at M.G.H. follows the national pattern. The problem is one of demand and distribution rather than shortage.

The answer to the Hospital's need for nurses has been sought in two ways; through changes in the School program, and through modifications in the plans for Nursing Service. A new program for the School of Nursing was introduced in the fall of 1948. Graduation Exercises for the first class of 104 students in this experimental program are to be held on June 15. The primary aim in the experiment was to determine whether or not a bedside nurse could be prepared in less than three years time. Because the state law in Massachusetts, and in most other states, requires a minimum of three

years for all registered nurses graduating from a hospital school, the program was divided into two units: an educational period of twenty-eight months, during which the student meets all state requirements in terms of class content and clinical practice; and an internship of eight months during which the student has opportunity to develop skill in patient care, and to become oriented to the responsibilities of graduate nursing service. In acknowledgement of the large amount of service given to the Hospital by the nurse interne, she receives a stipend of \$30.00 per month. Thus in her last year she may have a small measure of financial independence.

Since this new program began the enrollment of the School has increased from 241 to 387, a gain of 38-%. Recruitment has been carried on actively in spite of the growing number of applicants. Applications for fall classes now outnumber possible admissions five to one. In the spring the ratio is usually three to one. As against the rate of over 30% annual drop-outs from schools of nursing in the country as a whole, our loss for 1950 was 6.5%.

Such an increase in the number of students, combined with the acceleration of the teaching schedule, has aggravated the need for more housing, teaching, and recreational facilities. 90 applicants have been accepted for September, 1951; the maximum number which can possibly be accommodated in our class rooms. As registration of the incoming class precedes graduation of the September, 1951 class, it is impossible to find rooms enough for the entire School. As in 1950, we shall again give housing allowances to seniors who will move out into nearby apartments in August.

The Coordinated Program conducted by Radcliffe College and the School of Nursing is growing slowly. In the fall of 1950 the Simmons

College School of Nursing affiliated with the Coordinated Program. The total collegiate group at the School of Nursing during the summer of 1951 will be 76 students; 36 of whom will live at Simmons College. 27 will remain at M.G.H. after the summer session is over for their two years of clinical experience.

Space for student activities is also a problem. The art classes use the class rooms. The Glee Club and the lecture groups gather in the Walcott or Thayer living rooms. The basket ball team, for lack of a gymnasium at home goes to the Peabody Settlement House. The student newspaper staff has a corner in the Walcott House boiler room. The Senior Class despairs at the cost of the Peabody Playhouse when their annual play is staged. The Student Organization meets in the Moncley Rotunda, for no other room is large enough to accommodate the membership, in spite of the fact that many will be absent and on the wards for evening assignment. Only the bimonthly Friday night informal dances seem always to find an appropriate space in the Walcott House living room.

For housing facilities there is hope. Funds are available to begin the first unit of a nurses' residence in the fall. Whether enough money can be secured to include class rooms and adequate space for recreation in the second unit to be built is still a question of great concern.

One answer already made to the shortage is a larger number of graduates from the School with a patient centered curriculum designed to prepare young women for the practice of nursing in the shortest period of time consistent with good nursing education.

A second answer to our M.G.H. problem is being sought through a variety of plans. Advertising brought no employable nurses. Con-

structive publicity did have a very definite affect on the numbers of nurses, licensed attendants, and aides who applied. But the supply of nurses which more than compensated for resignations between January and March, disappeared entirely in May. In 1941 a typical Baker floor staff for twenty-four hours was comprised of 17 graduate nurses, including 2 head nurses, 2 second or third year student nurses, 1 secretary, 2 ward helpers and 2 or more orderlies. In contrast today, with the shortened hours, there may be 6 graduate nurses including 2 head nurses, 1 nurse interne, 2 second year students, 6 students who have been in the School for 8 months, 1 secretary, 8 aides including 3 nursing orderlies. Or, there may be a total of 10 graduate nurses, 1 secretary, 3 licensed attendants, 3 student attendants, 7 aides including 3 nursing orderlies, and 3 ward helpers. The General Hospital wards have shown similar changes.

Hospital aides were introduced in the General Hospital five years ago; young men and women trained briefly as a group in the class room in simple nursing techniques, and then supervised in their practice on the wards. This training program has continued constantly until today aides are employed in all divisions of the hospital and for many different types of work. In addition to assisting with patient care, aides have replaced staff nurses in the Central Supply Room. They have relieved a small percentage of the nurses on evening and night assignments. They are responsible for the care and sterilization of equipment in utility and treatment rooms, and "suction" rooms. In the General Hospital a small core of men aides have been taught to scrub to relieve or supplement nurses in the Operating Room as the need may arise.

Before 1941 the trained attendant was found to be a valuable member of the Baker nursing personnel. But trained attendants either

felt insecure on the active Baker floors, or the M.G.N. personnel policies did not meet their needs, for the number remained small. In November, 1950 the team plan for nursing care was introduced at the Baker. In April, 1951 an affiliation was begun with the Household Nursing Association in which student attendants are sent to the Baker Memorial for 13 months of training in bedside nursing. Since the first of the year the number of graduate licensed attendants has risen from 7 to 27. This group, with a definite occupational interest and training, promises to be more stable than untrained personnel whose interests are easily diverted to industry.

The head nurse is the nursing key to good patient care. But her assignment has been so changed by trends of the past few years that she often finds her day too short for time to spend with patients, or to supervise personnel in the giving of patient care. Assignment of personnel must be carefully planned when all members of the group cannot carry the same functions. Hours at the desk must be longer when the ward becomes a functional unit of the Hospital's accounting system. More doctors expect the head nurse to carry increasing responsibility for medical orders. It would be interesting to have prewar figures for contrast to see how medical changes have affected the head nurse's activities today. On the large Baker floors it is not uncommon to have as many as 77 doctors, by actual count, come to a floor between 7 A.M. and 7 P.M. to see patients. It is also not uncommon to have each of 2 members of a visiting surgical team rewrite a patient's orders within that same 12 hour period. When such a floor is fully occupied there may be as many as 6-7 discharges, an equal number of admissions, 3-4 operations, 3-4 patients prepared for operation, 2-3 patients sent to X-Ray, in a 12 hour period.

Last fall assistance was secured from the United States Public Health Service for a study of head nurse functions. 4 General Hospital and 2 Baker floors were studied. This study will shortly be published. It shows a disproportionate amount of time spent on clerical activities, too little time available to know patients or plan the administration of the ward, and a shocking number of unnecessary interruptions. Most of these facts were known to us all before, but the head nurses who were studied and others who shared in the tabulations have been stimulated to seek ways whereby the head nurse can be freed to do the work which only she can do.

The first change to be put into effect was the team plan. In the team plan a staff nurse or a nurse interne acts as leader for a group. The group may include a licensed attendant, a student attendant, or a nursing orderly. Under the guidance of the nurse the team cares for a group of patients, each member of the team carrying out the functions for which he or she is prepared. The team leader plans with the head nurse, interprets the plan for care to the team members, works with them or supervises as the need may be. She cares for the more critically ill or the emotionally disturbed patients in the group, gives the medicines, does the treatments which cannot be done by auxiliaries, and does whatever teaching of patients is appropriate.

This plan relieves the head nurse to give more oversight to the ward activities in general, and to patient care in particular. It stimulates the staff nurse and makes her work more interesting because she, too, has opportunity to know her patients better. It offers more security to the auxiliary workers some of whom have chosen to work at M.G.H. because the team plan was in use. Most important of all, the patients have expressed appreciation for the continuity of care, and the interest expressed for their individual welfare, which the team provides.

Five floors are now using the team plan. Others will adopt this method as rapidly as teams can be formed and leaders prepared to guide their teams. But the answer is not to be found only in numbers or in assignment of workers. A full time supervisor is now assigned to investigate needs for new equipment, methods of improving the care and use of equipment, and means for reasonable standardization in all divisions of the Hospital, which can bring significant economies as well as facilitate patient care. Our next need is for a worker who can study our methods of nursing care and explore ways in which they too can be simplified and improved to the end that there is more time for patient care.

Better patient care and enough of it to keep all desired beds open is the only justification for seeking more graduate nurses. A well organized plan for nursing care, time and the facilities with which to give good patient care, a reasonable hour schedule, a stimulating in-service education program, active interest in the nurse and her problems are the major factors which hold graduate nurses. From these factors Nursing at M.G.H. has drawn its objectives for 1951.

6-6-51
BS:BF

Ruth Sleeper, R.N.
Director of the School of Nursing
and Nursing Service

A D D R E S S

by

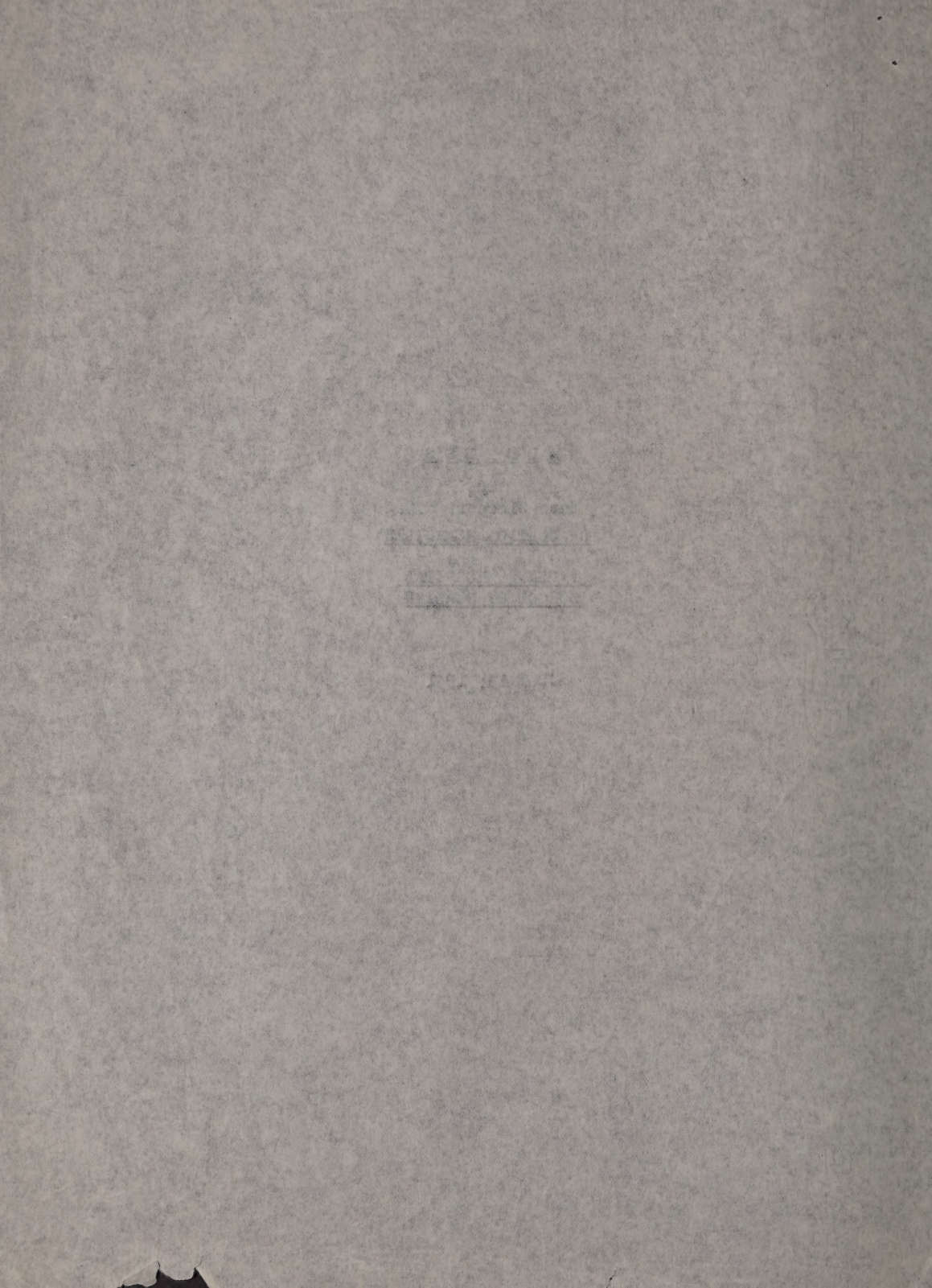
Ruth Sleeper, R.N.

GRADUATION EXERCISES

FAULKNER HOSPITAL

SCHOOL OF NURSING

JUNE 15, 1951



GRADUATION ADDRESS

PAULKNER HOSPITAL

JUNE 15, 1951

Recently it was necessary for me to spend a weekend in New York . Not having any special plans there for the weekend, I decided to use my time to good advantage, and to prepare for this meeting tonight. Being a distance away from you, my thoughts took the shape of a letter. It was a letter from one nurse to another, a letter from an older woman, a big sister, perhaps, to a younger sister, who was soon to start forth on a new and challenging life; a life that the older woman had tried; found both challenging and satisfying. And so now I read my letter to you -

Dear Senior in the Graduating Class of 1951:

This is my second trip down to Lake Success to attend the meetings of the Commission on the Status of Women. This Commission is appointed by the Economic and Social Council of the United Nations. As in the four previous sessions, the Commission is trying to solve some of the problems which confront women in undeveloped countries, in trust territories, in the non-selfgoverning territories, and in great democracies such as our own. The agenda this year includes such topics as political rights of women, the legal status of women, the nationality of married women, the repatriation of Green children not yet returned to their parents, and the status of nursing. The delegates come from fifteen countries ranging in size from the Union of Soviet Socialist Republics to Cuba and Haiti. Some of them are lawyers, one is a judge, others are teachers, one heads the volunteer nursing services of her country, one is a social worker. Around the table sit representatives from the World Health Organization and the International Labor Organization of the United Nations, and representatives such as I of the non-governmental groups interested in the welfare of women everywhere. You would be very

proud of your sex if you could take my chair for a few minutes to observe how these representatives are planning to help women, and through them to open up new possibilities for happier lives for all people. You would have, I believe, as I have, a great sense of humility and a tremendous feeling of obligation for all the benefits we receive under our Government, our law, and in our educational and health systems.

One cannot listen to the discussion of women's opportunities without realizing how much we hold of the world's welfare in our hands. If we will use them, we have half of the votes to elect the men and women who will direct the national and the world governments. We are the mothers whose love and teaching lays the foundation for security and constructive living for on-coming generations. In our group is a large proportion of the world's teachers who will have a major share in shaping the thinking and the mode of living of the people in these generations. And in forty-five countries there are over a million of us who have chosen to join the medical science team to care for the sick and promote the health in our communities.

Have you seen the report on nursing issued by the World Health Organization in 1950? If you have not, it would be worth your while to send to the United Nations in New York for a copy of it. Much of the content is directed toward countries where professional nursing is not yet developed. It deals with the need for nursing personnel, their use, the educational program and recommendations to the various units of the United Nations and to our own International Council of Nurses. Interestingly enough this report states that professional nurses are essential in a country if medicine and public health are to advance, and the health of the country is to be improved. Are you a bit surprised to discover that the men and women in the World Health Organization consider our profession of such importance? Unfortunately, some people we both know will tend to treat this statement quite casually, as if it were directed

entirely toward the undeveloped countries like Equatorial Africa where nursing education and practice as we know them have only begun. But, I have found as I listened to these women on the Commission that all such statements must be regarded in their proper perspective. To us, here in the United States, this statement might read that the health program can only advance if we have more nurses, or better nurses, or nurses who are willing to undertake and to stick to the job that needs most to be done. True, we have much to be proud of in our country but as long as there are people who are sick and need nursing care, or people who could live happier more productive lives if necessary health teaching were available, we cannot sit back complacently. It would appear that we are doing no better with what we have than Africa or rural India where few if any nurses exist.

It is a real treat to have no great responsibility for the conduct of a meeting, and to have time to sit and to think about the discussion with all its ramifications. You would have been thrilled to realize that of all the topics discussed by this Commission, the status of nursing was the one on which there seemed to be most agreement. Nurses are essential alike to the children, the families, the schools, the industries, of all countries.

The need is everywhere. The opportunities are legion. The contrast between the opportunities which lie before you as you enter into graduate life today, and those before me almost thirty years ago, in many respects is startling. The realization of these differences made me wonder how well you would use yours. It made me question too if I were starting again what would help me to use my opportunities to the best advantage. And so I made a mental list which went something like this. I believe it would have helped me if I had paid more attention to what was going on about me in government - all the way from my own town hall to the national congress. I wish I had done more reading so I would have known both sides of the political question. True, I might still

be confused, but then I could cast my vote in a state of informed confusion rather than ignorance. I might have had the temerity even to write to my congressman as a good citizen should do.

I wish someone might have helped me to see nursing as a professional service for which I had been prepared at considerable community expense. I trust I should not be misled into thinking that I had earned all of my education although my efforts had been vigorous and sincere. No student can ever earn or pay in full for all education. It is not a matter only of what education costs in money. True, education in nursing, as in any profession, is a handing on from one generation of ideals, spirit, knowledge and technique. A school can pay for time, but never for interest, or spirit, or ideals. I hope some one would help me to see these values that I might wish to make a fair return to those who had provided them. It has been said "One can never repay in gratitude; one can only 'pay in kind' somewhere else in life." Regardless of how the pattern of my life may develop, it would be my hope that I could continue to find opportunities in the community to give back "in kind" some of these values in my education.

Then, I would wish someone to help me see what it really means to be a nurse in a changing world. I can almost hear you say "Oh, I know about that. The old graduates on the floors say 'It wasn't like that in my day'. But I've been given an up-to-date preparation. I'm ready for the new world." And so you are today! But what about tomorrow? In the last few years I have seen the whole warp and woof of nursing change. Whereas I spent hours doing septic dressings, you spend hours giving antibiotics. Where I used many precious hours to clean bedside units or to make empty beds, you now concentrate on the nursing care which requires more skill, and learn to direct a team of auxiliary workers. Where I remember in the 1930's a surplus of nurses, you know only an overdemand which seems insatiable. How I wish someone could

have helped me envision and to face these changing trends, so that I could have understood and prepared for them wisely. Did you read Alice in Wonderland long ago? How fantastic all those adventures seemed. Yet, honestly, the world Alice lived in was hardly more topsy-turvy than that in which you will start your adventures in nursing. As with Alice, it helps early to realize that today one must run to keep from standing still.

Here I have gone on for several pages lecturing you. So now for some news. Many of my old friends have been at the meetings here this weekend, on their way back from the Convention of the National League of Nursing Education in Boston. They have had a wonderful time. Some are now going home to their jobs refreshed. Others are staying over for a day or two to study again how the 6 National Nursing Organizations can be combined into two, and made to work more effectively for nursing service, for nursing education, and for the nurse herself. How fine it would be if you could meet these women. There are staff nurses in the group, who are really becoming masters of nursing, teachers in three year schools and some in university schools, one a Chief Nurse of the United States Public Health Service, one the Editor of the American Journal of Nursing, another just back from the meetings of the W.H.O. in Geneva. Several too, had pictures of their children who looked as if the mothers had used their nursing knowledge well. It was really thrilling to hear these mothers tell of their activities in nursing as part-time workers, on school boards, in parent-teacher associations, and on boards of visiting nurse organizations. As I write this I am struck with the picture they all make, together, a real cross section of nursing, and a good cross section of women. Also I have been impressed again with the fact that the recreation found in these professional meetings outweighs all the recreation tucked into the spare minutes between meetings.

Everywhere people are talking about the shortage of nurses. Wouldn't it be grand if nurses could write a series of articles which would explain clearly that the United States has more nurses than it has ever had before? You and I must learn to do a better job in interpreting the demands so at least our acquaintances will know the truth. They say we need 65,000 more graduate nurses for civilian needs alone today. No one knows how many licensed attendants we actually need, and few nurses really seem to understand how these women can work to advantage in the nursing team. Unfortunately, more hospitals are being built, the military needs are growing, and more nurses are needed for public health in areas where communities have neither hospital nor health personnel. It's very comforting to know that the profession chosen offers unlimited opportunities for work, isn't it? But how are you and your classmates going to choose the right position; the one where you are needed, and the one where you can build the soundest experience for your future? How will you resist the glowing offers of positions for which you are not prepared? How will you build your experience wisely as the curriculum in your school was built? In that you started with the simple and progressed to the complex. So build the wise ones who plan for their futures. A wise friend of mine once said, "In the beginning you may earn more than you are paid, but the time comes for most people when they are paid more than they earn." Even though you do not plan to make nursing your life's career, it is still a sound principle to follow. No woman today can safely lay aside her career as finished when she marries. The country's economy promises to demand that the women of the family, sharing with the men, will work when children are grown. The sounder the original experience, the better the future possibilities.

Speaking of this so-called shortage! It is possible that I, and you too, will never work in a situation again where there will be enough nurses. At first reading that sounds like a discouraging picture. But on the contrary, it is a very stimulating thought. Scarcity is surely the mother

of invention in nursing. When you think of it, we have already done a great deal to make up for the lack of professional nurses: the licensed attendant group is growing, the trained-on-the-job aide has appeared, ward clerks have been added to the staff, the team plan has been introduced to integrate all of these new workers into a functioning unit which will meet the patient's needs. We've studied methods of carrying out procedures to facilitate patient care. Given a bit more time, we shall probably develop scientific time and motion studies which can help us reduce the minutes needed in our nursing procedures. How much more the patient would enjoy her bed bath if we used 75 motions instead of 100, or if it took 15 minutes instead of 20. How much time could be saved if every empty bed could be made in 8 minutes instead of 10. How much more energy and time would be left for nursing care if we selected or devised equipment which could be handled more easily, or if our nursing units could be rearranged to save steps. Well, its an interesting topic to ramble on about.

But it is time for this letter to close for you have had enough, and I must go back now to prepare my report on the meetings of the Commission on the Status of Women. Tomorrow, I expect, will be the final meeting of the session. The women will go back to their countries leaving behind a sheaf of resolutions, and the hope that their efforts will bring happier lives to women, and so to people everywhere. Fifteen women's voices are so soft to speak so loudly. It has been said "there is not enough darkness in all the world to put out the light of one small candle". So, too, it must be that even with war and all the din of daily living, the voices of these fifteen women shall not be drowned out.

The "supreme moment of any action is the beginning." May you enter upon your new life with the zest and courage of the adventurer. May you find in this new life the satisfactions of achievement.

WE STUDY OUR BASIC PROGRAM
by
Ruth Sleeper, R.N.
Massachusetts General Hospital School of Nursing

In 1947 the Faculty of the School of Nursing decided that the time had come to stop talking, and to begin to act upon the group thinking.

We had three major concerns. First, the student time schedule needed attention. Patriotism during the war years had made the institution as a whole cling to a long hour schedule for all professional workers, all professional students and lay personnel. The war years and their demands were now well behind us.

Second, the curriculum as a whole needed revision. New trends in the social and medical sciences were evident and the prewar curriculum was steadily growing inadequate.

Third, student assignments required practice in many instances beyond the point of safe and reasonably skilled performance. Constantly before us was the unanswered question; how long a period of time is necessary in each clinical service to provide sound learning?

The modification of the hour schedule offered no great problem. But neither money, time, nor trained personnel were available to make studies for curriculum revision, or controlled studies of student learning experience. There seemed only one way to answer our questions, and that was action which would put our ideas into a practical plan and the plan into effect. Then we could watch the progress with critical eyes and make changes as problems became evident. In this way we would discover for ourselves the answers we sought.

We had no preconceived ideas as to the length of time our new curriculum should require. We did know the kind of product desired. The

graduate of the program should be able to care for all types of patients admitted to the home hospital; she should have sufficient knowledge of other conditions found in the community to enable her to work effectively in other institutions whose clinical facilities were different, or more inclusive than our own; she was to have sufficient knowledge of the community and the families from which her patients came so that she would understand total care, and share in the contribution which the hospital would make to that care; she should have a sound basis upon which to build, if at a later time she wished to continue her studies in nursing; she should have and know how to maintain her own physical and mental health; she should be ready to accept her responsibilities as a professional woman and a citizen.

Fortunately the clinical facilities of this hospital are broad. There are segregated services in medicine, surgery, pediatrics, obstetrics, psychiatry, and several medical and surgical specialties. Patients on most of these services are cared for both in the hospital and in the out-patient department. The fact that the obstetrical and psychiatric services are not well suited to student learning made no difference in our original considerations, for we were dealing with outcomes, not the plan for teaching. So the original listing of clinical fields in which the graduate of the school should have sufficient supervised practice to develop reasonable proficiency read as follows:

Medical nursing	Orthopedic nursing
Surgical nursing	Urological nursing
Operating room nursing	Gynecological nursing
Pediatric nursing	Neurological nursing
Obstetrical nursing	Dermatological nursing
Psychiatric nursing	Isolation

Adjacent to this hospital is another independent voluntary hospital caring for patients with eye, ear, nose and throat conditions. Many patients

with these conditions come to the private services of our hospital for care. So we added to the list of clinical fields

Eye, ear, nose and throat nursing.

Earlier, the statement was made that the faculty had no preconceived ideas as to how long the program would require. There were, however, three time factors which were given careful consideration: namely, State Board requirements, time necessary for orientation and subsequent adjustment on a new service, and the effect on patient care and ward management of frequent changes of nursing personnel.

After study the time schedule was set down as follows:

Preclinical period	- 24 weeks
Medical nursing including diet therapy	- 13 weeks
Surgical nursing	- 13 weeks
Operating room including central supply	- 8 weeks
Obstetrical nursing	- 13 weeks
Pediatric nursing	- 13 weeks
Psychiatric nursing	- 13 weeks
Orthopedic nursing	4 weeks
Gynecological nursing	- 4 weeks
Urological nursing	- 4 weeks
Dermatological nursing	- 4 weeks
Neurological nursing	- 4 weeks
Eye, ear, nose and throat nursing	- 4 weeks
Isolation	- 4 weeks for students meeting health requirements
Total time needed for desired clinical assignments (No experience, other than 1 day of observation, with the Visiting Nurse Service is available to three-year schools in Boston)	
121 weeks	

As it did not seem possible to change the vacation from 9 to 12 weeks at the time, it was decided to proceed, but with the understanding that the modification would be made as soon as possible.

Time (temporarily) added for vacation	- 9 weeks
Total time needed for basic educational program	-130 weeks

Massachusetts like many other States has a three year requirement for the diploma school. The question naturally, therefore, arose as to how the State registration for graduates could be protected while we were studying, through actual trial, the results of a shortened program. Obviously we needed to plan a program which covered a three year time period even though our teaching plan could be provided in 28 months.

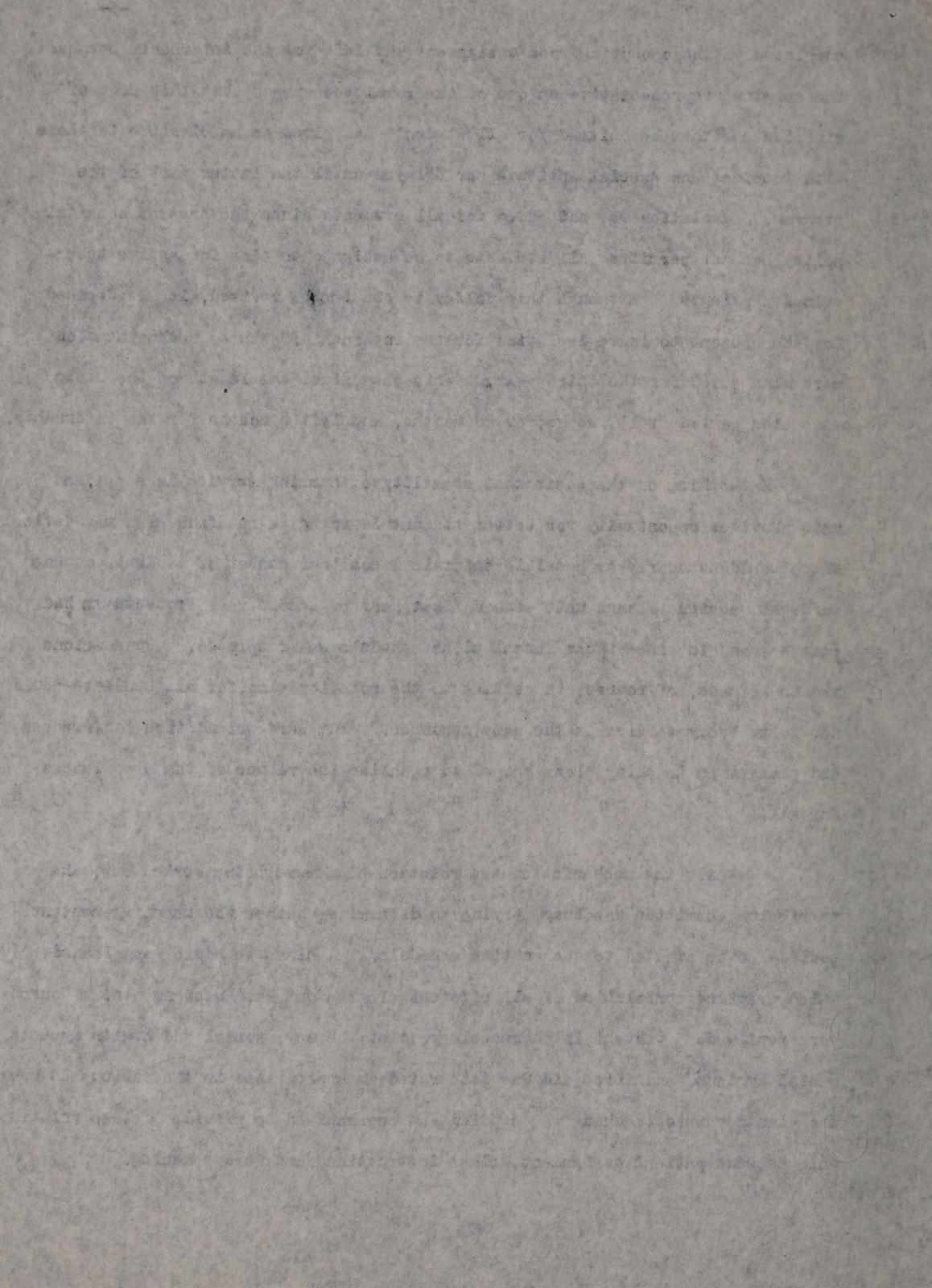
It was decided, therefore, to establish a second period in the program in which the student would concentrate on mastery of skills and become oriented to graduate nursing practice. This period was to be devoted entirely to nursing practice. There was to be no attempt to include administrative or teaching skills through introduction to such activities as head nursing or classroom teaching. Because the plan for this period, following the basic educational period, seemed to compare so closely with that set up for other professional students in the hospital, it was designated as the internship.

Further consideration of the plan resulted in the withdrawal of neurological and eye, ear, nose, and throat nursing, and operating room, from the basic educational program, and the inclusion of practice in these fields in the internship period. The neurological experience was postponed in order that the student might have more clinical experience and knowledge to bring to the care of the critically ill patients on the neurological wards. The eye, ear, nose and throat experience was postponed for the most part because arrangements for the four week affiliation were delayed until after the rotation plan was almost

completed. The operating room assignment was left for the internship because the surgical representative on one of the committees urged that this area of experience either be omitted for all students and given as an elective to those with interest and special aptitude, or delayed until the latter part of the program. Isolation was not added for all students since the present hospital policy has not permitted all students to be assigned to care for active tuberculosis patients. Although this policy is about to be revised, it was decided for the present to leave isolation for the internship. Three weeks vacation were also saved for the third year. This then fixed the length of the basic education period at 119 weeks, or 28 months, and left 8 months for the internship.

Working on the basis that stability of nursing service in a patient unit provides opportunity for better student learning, a rotation plan was devised which would as nearly as possible maintain a constant number of students on each ward, and assign to each unit either first year or second year students who had classes, and internes whose formal class schedule was completed. Concessions had to be made, of course, in setting up the rotation plan, for all students could not go to every service in the same sequence. But ward orientation conferences and changes in teaching plans helped to equalize the values of the experiences for all.

While the mechanics of the rotation plan were being worked out, the curriculum committee was busy, trying to determine whether the teaching content could also be adapted to such a time schedule. A class schedule was planned which provided correlation of all clinical classes and ward assignments. Courses were reviewed. Content in pharmacology, diet therapy, social and health aspects, mental hygiene, and first aid was integrated as appropriate in the various courses. The plan for ward teaching was studied and reorganized to provide a close relationship between patient assignment, class instruction, and ward teaching.





The budget for the School was also included in the study. An estimate was made of the cost of the proposed program for comparison with the current plan. As the hours for ward practice were to be markedly reduced by the modified hour schedule during the educational period, and made comparable to graduate nurses' in the internship, it was necessary to reevaluate student services, and to plan for an increase of staff nurses or other nursing personnel to assure sound patient care. It was also necessary with the shorter hours to add more clinical instruction to insure the best use of the ward time for learning. There was little probability that staff nurses could be secured in sufficient numbers to prevent evening assignments for first year students, or night assignments for second year students as planned. So plans were made to increase teaching on evening and night assignments. As internes were to make a large and obvious contribution to nursing service it was decided to pay a small stipend in recognition of this contribution to the Hospital. All this was included in the budget presented to the Hospital Administration, to the Advisory Committee and Trustees.

A faculty committee meanwhile was preparing an in-service program for the internship with instruction in advance of that planned for students in the basic educational period: discussion of "advanced" patient care and conditions, team leadership, graduate nurse responsibilities and opportunities.

That the hospital family might distinguish between student and intern a new student cap was adopted which was obviously different enough from the standard school cap to be readily evident. It was decided that the student cap should be worn from the day of entrance until the end of the 23th month, when a capping ceremony for nurse internes might be held.

The first class for the program was admitted in September 1948. The plan proceeded and we watched with critical eye. It was hoped that some

objective and valid means could be found to measure the progress of the students during the 28 month student period, and to compare them with graduates of a 36 months course.

The first class of internes was capped in January 1951. Without any opportunity to prepare they were given the Graduate Nurse Qualifying Examinations. These examinations were prepared by the National League of Nursing Education for use especially by colleges or universities to determine the clinical nursing needs of graduates applying for the nursing program. The following graph shows the test results for the first class of students graduated from the program when the 28 months basic educational period had been completed.

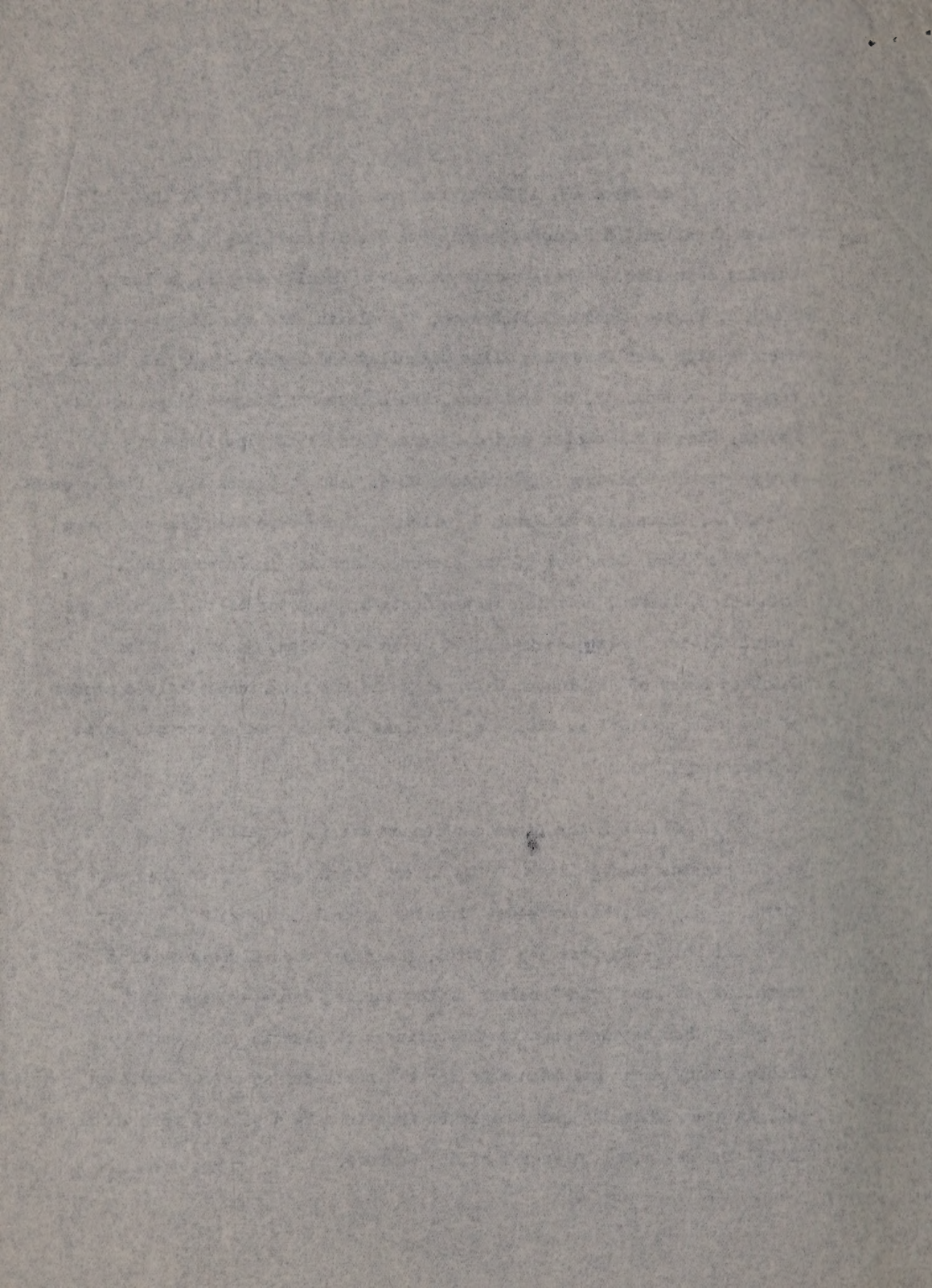
Although the nursing care given by the internes as compared with that of graduates from the previous 36 months program appears to substantiate the results of the graduate nurse examinations, no conclusions can be drawn at this time. The program is more expensive than the former plan, because student hours are reduced, more instructors have been added, and student assignments during the first 28 months are made according to educational needs. There is more, rather than less, teaching because ward teaching has been increased. However, it is true that students enjoy the program and today are the most effective recruiting agents for the School. Applicants are attracted to the School because of the new program. Drop-outs, for all reasons, after the pre-clinical period have been reduced to 0.8%.

The first class will be graduated in September 1951. In comparison with previous classes it now appears that a slightly higher proportion of the numbers of this class, as compared with previous classes, plan to return as staff nurses. Their reason for selecting staff nursing: they like to take care of patients.

Now as the first anniversary approaches it is time to review our findings. We know the plan has both weaknesses and strengths. The rotation program is already under scrutiny, the curriculum committee is still at work, and the ward teaching committee has already modified the program for the nurse internes. Since this is a study through action, no one of the faculty knows now where or when we shall end. But we are slowly answering our own questions, and solving our own problems, as we take action together.

On March 23, 1952 nurses from 9 countries met at the World Health Organization Headquarters in Geneva, Switzerland to discuss nursing education. These nurses came from Brazil, Canada, England, Finland, France, India, Switzerland, Yugoslavia, and the United States. Meeting with them were Miss Olive Baggallay and her staff at WHO, three resource persons, Mr. S. W. Barnes, House Governor, Kings College Hospital, London, Miss Cora DuBois, Social Science Consultant, Institute of International Education, Washington, D. C., and W. Carson Ryan, Professor of Education, University of North Carolina. There were also two observers, Miss Ellen Broe, Director of the Florence Nightingale International Foundation, London, and Miss Yvonne Kentsch, Director of the Nursing and Social Service Bureau, League of Red Cross Societies, Geneva. Miss Kathleen Leahy of Washington University who has been temporarily a member of the Nursing Staff at WHO, made the plans for the conference and acted as secretary.

This was the first session on nursing education to be held at WHO outside the meetings of the Expert Committee. After a welcome by Doctor H. S. Gear, an Assistant Director General, on behalf of Doctor Brock Chisholm, the Director General, the group was welcomed by Miss Baggallay and Miss Lyle Creelman of the Nursing Secretariat of WHO. The group then settled down to the business of planning an agenda. Although many plans had been made for the meetings, no agenda had been set, in order that the group might be free to make a plan of work which fitted the needs and interests of the members.



Actually the group was in many respects a homogeneous one. All members but one had studied in Canada, England, or the United States. Seven of the members were directors of schools of nursing. The other two were closely involved in nursing school problems and needs; one as Education Officer for the General Nursing Council for England and Wales in London, the other as Chief of the Department of Middle Medical Schools for Slovenia, the Department responsible for nursing schools in Yugoslavia. All but one of the schools represented offered the diploma program. Probably the greatest differences between the schools lay in the degree of emphasis on public health nursing in the curriculum. The major objective of one diploma school was the preparation of the public health nurse.

The main theme chosen for the agenda was "What kind of nurse do we need in the various parts of the world, and how can she best be prepared." The discussion brought out the differing demands of the health needs and the countries' social structure, but common agreement was finally reached on the second day.

It was agreed that the kind of professional nurse needed in all parts of the world is one who is prepared, through general and professional education within her social structure, to share, as a member of the health team, in the care of the sick, the prevention of disease and the promotion of health.

This will be a nurse who:

- 1) possesses the personality, the education, both general and professional, the degree of maturity and the possibility of development which will enable her to work effectively within her social structure;
- 2) is prepared to recognize and to adjust to changing social, economic, medical, nursing and health situations;

- 3) is well adjusted in her own living, in her work, and in her relationships with others; utilizes her education to help her find security and satisfaction in her living and her work and to help make the necessary changes for improvement in her situation; has developed a sense of personal and professional responsibility;
- 4) has the capacity for and the will to seek continued growth and educational development;
- 5) is equipped, through generalized preparation, to work in all fields of nursing;
- 6) is prepared to give total nursing care, which includes the social, physical, mental and emotional aspects;
- 7) is prepared
 - a) as the nurse-member of the health team, to analyze the nursing needs - physical, mental, emotional and social, of individuals, both sick and well, and to plan the nursing care necessary to meet their needs;
 - b) to carry out nursing techniques skilfully herself;
 - c) to teach and supervise auxiliary workers, patients, families and community groups appropriate nursing and health care;
 - d) to administer in selected situations, on the wards and in community nursing programmes;
 - e) to participate in community programmes and nursing organizations.

It was then in order to consider the method by which this nurse might be prepared most effectively. During the discussion interest was gradually aroused in the situation approach and ways of using this method of teaching were considered in relation to the various social cultures represented. Reports were prepared and given to show how a curriculum might be adapted to the situation approach in a school in Brazil, England,

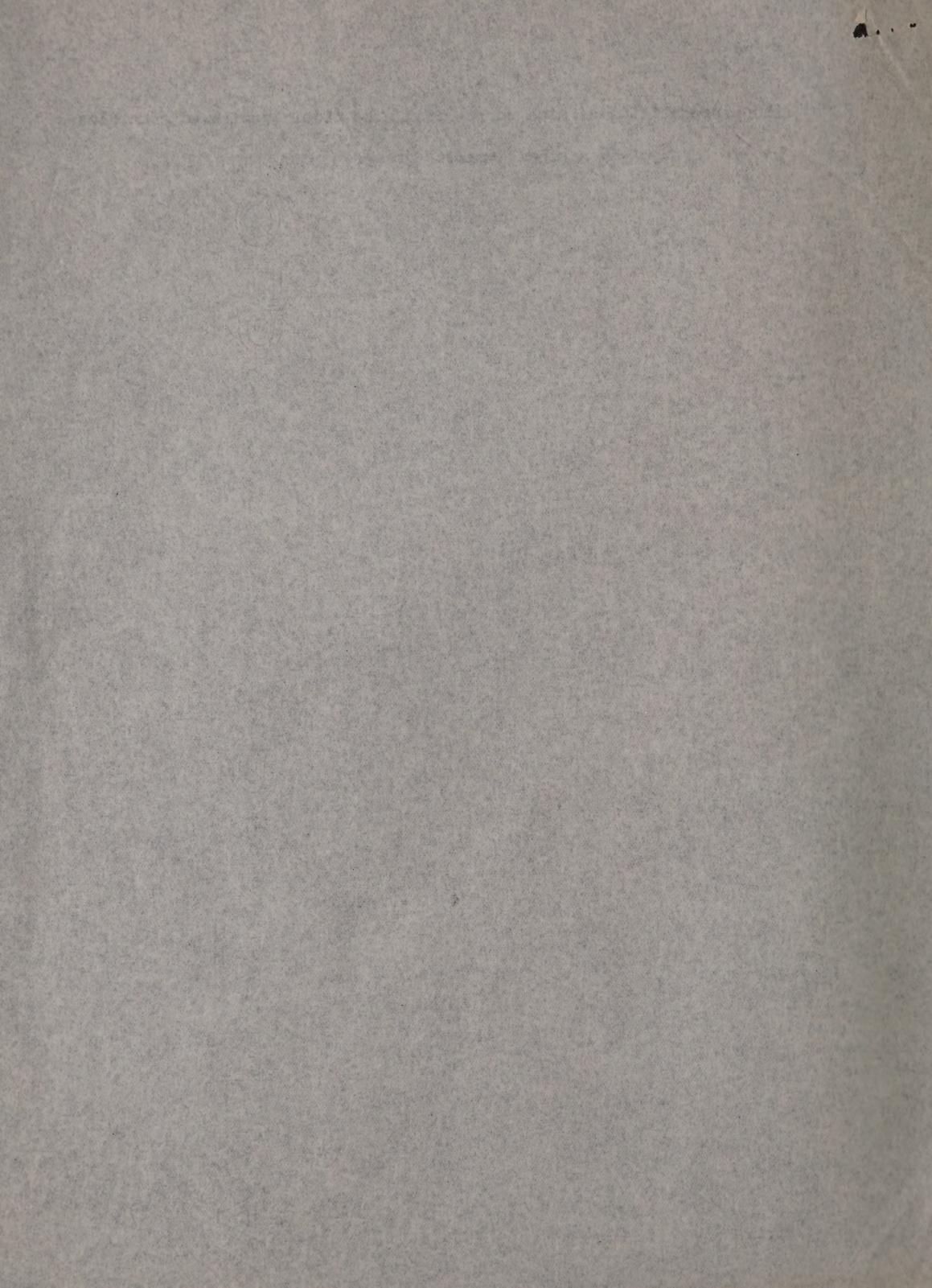
Finland, France, India, Switzerland and Yugoslavia.

Much is said and written of the formation of working groups here today. That nine nurses from nine countries could have been integrated into a unified group so quickly and with such ease is a tribute to the preplanning made for this meeting. There was the freedom for the group to work out its own agenda. The chairmanship was rotated daily from one volunteer to another. Even the high backed chair, customarily placed at the end of the conference table at WHO, moved to the middle for the opening session, had disappeared entirely by noon of the first day. Detailed materials completed for cineographing during a morning session were ready for use in the afternoon, for the secretaries too shared the enthusiasm of the group to see the job through.

But there was more than the work of the conference to unite the group. The spirit of the meeting was apparent in the many plans to make all comfortable, the get acquainted tea at Miss Creelman's apartment, the welcoming party given by the Secretariat, the buffet suppers which gave opportunity to meet members of the WHO Staff at Miss Baggallay's home, the weekend trips to country and mountains, the good wishes of Doctor Doralle, Deputy Director General who declared the meeting adjourned.

The results of such a meeting cannot be measured by one small report. For no report can convey fully the growth which takes place in personal understanding or in respect for nurse and nursing in other social cultures. Nor can the report show the farflung changes possible when individual members of the group at home recount ^{the meeting} ~~it~~, infusing into ^{their description} ~~it~~ again

the personalities of nine nurses from nine widely scattered countries
became through WHO a single working group.



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Department of Music

School of Nursing

